

This electronic thesis or dissertation has been downloaded from the King's Research Portal at <https://kclpure.kcl.ac.uk/portal/>



Addiction, alienation and assertiveness in Saudi and English drug addicts

Abdulaziz Al Saud, Bazza Saud

The copyright of this thesis rests with the author and no quotation from it or information derived from it may be published without proper acknowledgement.

END USER LICENCE AGREEMENT



Unless another licence is stated on the immediately following page this work is licensed

under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International

licence. <https://creativecommons.org/licenses/by-nc-nd/4.0/>

You are free to copy, distribute and transmit the work

Under the following conditions:

- Attribution: You must attribute the work in the manner specified by the author (but not in any way that suggests that they endorse you or your use of the work).
- Non Commercial: You may not use this work for commercial purposes.
- No Derivative Works - You may not alter, transform, or build upon this work.

Any of these conditions can be waived if you receive permission from the author. Your fair dealings and other rights are in no way affected by the above.

Take down policy

If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

**ADDICTION, ALIENATION AND
ASSERTIVENESS IN SAUDI AND
ENGLISH DRUG ADDICTS**

Bazza Saud Abdulaziz Al Saud

**Thesis Submitted For The Degree Of Doctor Of Philosophy
(PhD)**

**Institute Of Psychiatry
Kings College London
University Of London**

2006

ABSTRACT

Addiction research has been carried out extensively in the social sciences. In particular, attention has been focused on explaining the origins of addiction and developing treatments, spanning a range of drugs, from cannabis to heroin. This thesis will apply the theoretical concepts of alienation and assertiveness to drug use. This is based on the assumption that addiction is influenced by the degree to which a drug user is alienated from self, peers and society. The thesis will contend that if drug users become more assertive, they are less likely to become alienated, hence less likely to become addicted. These assumptions were forged into three hypotheses that were tested on drug users and control groups in the United Kingdom (UK) and the Kingdom of Saudi Arabia (Saudi), since few studies have investigated comparisons between these countries in this respect. Specifically, the following three hypotheses are researched in this paper: H1: drug addicts will have a higher degree of alienation in comparison with non-addicts; H2: drug addicts will be less assertive than non-addicts; H3: cultural differences will be detected between English and Saudi samples.

It was found that UK drug users were significantly more alienated than Saudi drug users. Control group comparisons showed that Saudi controls were significantly more alienated than UK controls, leading to the conclusion that cultural differences had a crucial role to play. In terms of assertiveness, it was found that UK drug users are significantly less assertive than UK controls on certain dimensions of the assertiveness scales. For Saudi samples, no significant differences were observed. Further, it was confirmed that strong cultural differences were detected between the two nationalities, arguably because the concepts of alienation and assertiveness are distinct Western concepts.

In order to address this, and to investigate alienation and assertiveness in Saudi Arabia more closely, a qualitative study was conducted. From this, it was concluded that the unproblematic transposition of these concepts leads to erroneous conclusions. By focusing on meaning, it was found that what to Western norms might be termed alienation is in Middle Eastern terms a shift to individual from collective identity formation. Paradoxically, 'lack of assertiveness' from a Western vantage point could in a Middle Eastern context be regarded as 'asserting the right to choose'. By focusing on the changing cultural identities in all sectors of Saudi society, it is argued that against this backdrop, the relative alienation of this sample reflects a shift from a collective conformist identity towards individuation in terms of forging a sense of self or core identity. The model of addiction provided by Standish (2003) is tested empirically, as it provides a clear synthesis of addiction in terms of the intra-personal, interpersonal and social dimensions it acknowledges, and because it clearly incorporates notions of alienation and assertiveness. Implications for theory and practice are discussed.

ACKNOWLEDGMENTS

My thanks and appreciation goes to my supervisors: initially Dr. Angela Summerfield, and later Dr. Maurice Lipsedge. They have taught me a lot, and it was a privilege to have worked with them over the years.

I would like to thank Dr. Andy Liefoghe, Dr. Ellen Balke, Dr. Simon Dein, Dr. Gina Pauli and Kate Hopkinson who have supported me over the years of this thesis, giving me the help and encouragement to persevere.

A heartfelt thanks to all the participants, both in the United Kingdom and Saudi Arabia. Through them, I have been able to gain insight into issues around addiction, alienation, assertiveness – and cultural differences. I hope their willingness to give their time and effort will result in a greater understanding of this field.

Special thanks to all my friends for their support and encouragement.

Last, but not least, I would like to dedicate this thesis to my family for their love, trust and support throughout my journey.

TABLE OF CONTENTS

CHAPTER ONE: ADDICTION	12
1.1. INTRODUCTION	12
1.2. DEFINING ADDICTION	13
1.3. EAST AND WEST: AN HISTORICAL CONTEXT FOR HEROIN ADDICTION	16
1.3.1. Drug Use In The UK	17
1.3.2. Drug Use In Saudi Arabia.....	22
1.3.3. Ethno Cultural Difference And Drug Use	28
1.4. MODELS AND THEORIES OF ADDICTION.....	31
1.4.1. Social/Environmental Models	32
1.4.1.1. Problems With The Social Environmental Model	35
1.4.2. Genetic/Physiological Models	36
1.4.2.1. Problems With The Genetic/Physiological Model.....	39
1.4.3. Personality/Intrapsychic Models.....	40
1.4.3.1. Problems With The Personality/Intrapsychic Models	44
1.4.4. Coping/Social Learning Models	44
1.4.4.1. Problems With Coping/Social Learning Models	46
1.4.5. Conditioning/Reinforcement Behavioural Models	47
1.4.5.1. Problems With Conditioning/Reinforcement Models.....	47
1.4.6 . Compulsive/Excessive Behaviour Models	48
1.4.6.1. Problems With The Compulsive/Excessive Behaviour Models	50
1.4.7. The Integrative Models.....	51
1.4.7.1. Problems With Integrative Models	52
1.5. POSITION OF THE THESIS	52
CHAPTER TWO: A THEORETICAL FRAMEWORK LINKING ADDICTION WITH ALIENATION AND ASSERTIVENESS	55
2.1. INTRODUCTION	55
2.2. DEFINING ALIENATION	55
2.2.1. Psychoanalysis and Alienation	59
2.2.2. Psychoanalytic Approaches to Addiction and Alienation.....	62
2.2.3. The Link with Assertiveness	67
2.2.4. Disease or Free Will?	68
2.3. DEFINING ASSERTIVENESS.....	72
2.3.1. Assertiveness and Addiction Research	75
2.4. POSITION OF THE THESIS	76
CHAPTER THREE: FROM THEORY TO EVIDENCE: OPERATIONALISATION AND METHOD	78
3.1. INTRODUCTION	78

TABLE OF CONTENTS

CHAPTER ONE: ADDICTION	12
1.1. INTRODUCTION	12
1.2. DEFINING ADDICTION	13
1.3. EAST AND WEST: AN HISTORICAL CONTEXT FOR HEROIN ADDICTION.....	16
1.3.1. Drug Use In The UK	17
1.3.2. Drug Use In Saudi Arabia.....	22
1.3.3. Ethno Cultural Difference And Drug Use	28
1.4. MODELS AND THEORIES OF ADDICTION.....	31
1.4.1. Social/Environmental Models	32
1.4.1.1. Problems With The Social Environmental Model	35
1.4.2. Genetic/Physiological Models	36
1.4.2.1. Problems With The Genetic/Physiological Model.....	39
1.4.3. Personality/Intrapsychic Models.....	40
1.4.3.1. Problems With The Personality/Intrapsychic Models	44
1.4.4. Coping/Social Learning Models	44
1.4.4.1. Problems With Coping/Social Learning Models	46
1.4.5. Conditioning/Reinforcement Behavioural Models	47
1.4.5.1. Problems With Conditioning/Reinforcement Models.....	47
1.4.6 . Compulsive/Excessive Behaviour Models	48
1.4.6.1. Problems With The Compulsive/Excessive Behaviour Models	50
1.4.7. The Integrative Models.....	51
1.4.7.1. Problems With Integrative Models	52
1.5. POSITION OF THE THESIS	52
CHAPTER TWO: A THEORETICAL FRAMEWORK LINKING ADDICTION WITH ALIENATION AND ASSERTIVENESS	55
2.1. INTRODUCTION	55
2.2. DEFINING ALIENATION	55
2.2.1. Psychoanalysis and Alienation	59
2.2.2. Psychoanalytic Approaches to Addiction and Alienation.....	62
2.2.3. The Link with Assertiveness	67
2.2.4. Disease or Free Will?	68
2.3. DEFINING ASSERTIVENESS.....	72
2.3.1. Assertiveness and Addiction Research	75
2.4. POSITION OF THE THESIS	76
CHAPTER THREE: FROM THEORY TO EVIDENCE: OPERATIONALISATION AND METHOD	78
3.1. INTRODUCTION	78

4.7.3. Hypothesis Three: Cultural Differences Will Be Detected Between Saudi And UK Samples.....	125
4.7.3.1.Differences In Alienation Between Saudi Samples And UK Samples	125
4.7.3.2. Differences In Assertiveness Between Saudi Samples And UK Samples	126
4.7.3.3. Conclusion On Hypothesis Three	127
4.8 REFLECTIONS ON CROSS-CULTURAL VALIDITY	127
 CHAPTER FIVE: A QUALITATIVE INVESTIGATION OF SAUDI DRUG USE	 131
5.1. INTRODUCTION	131
5.2. PURPOSE OF THE STUDY	132
5.3. ADDICTION, ALIENATION AND ASSERTIVENESS IN A SAUDI CONTEXT	136
5.3.1. Self-alienation: A Question Of Identity	136
5.3.2. Asserting Self In A Muslim Society	138
5.4. METHOD AND ANALYSIS	139
5.4.1. Background To The Study	139
5.4.2. Method: Interviews.....	140
5.4.3. Recruitment Of Participants	141
5.4.4. Procedure: Conducting The Interview	141
5.5. DESCRIPTION OF PARTICIPANTS	144
5.6. CONSTRUCTING A LENS FOR DATA ANALYSIS.....	148
5.7. ALIENATION AND ADDICTION.....	150
5.7.1. Primary Alienation: From Self	151
5.7.2. Thwarted Identities	153
5.7.2.1. Attaining The Identity Of Being An Addict	154
5.7.3. Conclusion.....	156
5.7.4. Secondary Alienation As A Result Of Drug Use.....	156
5.7.4.1. Stage One: Trigger Events.....	157
5.7.4.2. Stage Two: Using Drugs, Followed By A Reduction In Tension.....	157
5.7.4.3. Stage Three: The Withdrawal Stage	159
5.7.5. Conclusions	160
5.8. ASSERTIVENESS AND ADDICTION.....	160
5.9. CONCLUSIONS.....	161
5.9.1. Removal Of Support Structures.....	161
5.9.2. Thwarted Ambitions Or Desires.....	162
5.9.3. Beneficial Effects	162
 CHAPTER SIX: DISCUSSION	 166
6.1. INTRODUCTION	166
6.2. CONDUCTING THE STUDIES.....	169
6.3. IMPLICATIONS FOR THEORY AND PRACTICE	170

6.4. LIMITATIONS OF THE TWO STUDIES	175
6.5. CONCLUSIONS.....	177
REFERENCES	183
APPENDICES	209
APPENDIX ONE : LETTER TO PARTICIPANTS - ENGLISH.....	210
APPENDIX TWO : CONSENT FORM – QUANTITATIVE STUDY ENGLISH	211
APPENDIX THREE : P. H. F - ENGLISH.....	212
APPENDIX FOUR : A. S. Q - ENGLISH	217
APPENDIX FIVE : A. Q. - ENGLISH	221
APPENDIX SIX : LETTER TO PARTICIPANTS – ARABIC	226
APPENDIX SEVEN : CONSENT FORM – QUANTATIVE STUDY – ARABIC	227
APPENDIX EIGHT : P.H.F - ARABIC	228
APPENDIX NINE : A. S. Q. - ARABIC	232
APPENDIX TEN : A. Q. - ARABIC	236
APPENDIX ELEVEN : CONSENT FORM – QUALITATIVE STUDY – ARABIC	241
APPENDIX TWELVE : ARABIC STATISTICS – DRUG USAGE	242

INTRODUCTION

Ever since the dawn of time, the expansion of consciousness has been a central preoccupation and is arguably inherent to the human condition. Consciousness is both the most obvious and the most mysterious feature of our minds. On the one hand, what could be more certain to each of us than being the subject of an experience, an ‘enjoyer’ of perceptions and sensations, a sufferer of pain, an entertainer of ideas and a conscious deliberator? On the other hand, how do physical bodies in the physical world actually contain such a phenomenon? History reveals that ever since humans started eating certain plants, they discovered they made them feel different and the world was perceptually experienced in an altered sense.

These ‘drugs’ have become familiar to many beyond the confines of their earliest intended use. A striking example of this is coffee: although bought in packets and jars as a food, it fits all the definitions of a drug. Coffee is indigenous to Ethiopia where it was first consumed by chewing the beans or infusing the leaves; it was the technique of roasting and grinding coffee beans that rendered it drinkable. Its success was due to the popularity of the subjective experiences associated with using the substance, and as the Quran had banned the use of alcohol, coffee became the *ne plus ultra*. Dervishes used it during religious rituals, but beyond that context coffee houses rapidly developed, placing it firmly into a social arena.

The use of coffee in the social setting of the coffee house spread through the Arab world and to Turkey, Persia and beyond. The status of coffeehouses as establishments supplying mind-altering drugs, and as centres of sedition and dissent, led authorities in different countries to attempt to outlaw and ban the use of coffee. These attempts failed, and

were replaced by heavy taxation, making coffee a valuable source of revenue for the authorities. During the seventeenth century, coffee drinking spread to England and other parts of Europe. Coffee houses soon became important social, political and business centres, only supplanted when, on the importation of tea from British India, this beverage replaced coffee in Britain as the non-alcoholic drink of choice (notably also containing caffeine, as well as other stimulants).

This brief review of the history of coffee highlights themes not dissimilar to those currently preoccupying society, with respect to drugs such as opiates. Furthermore, it emphasises that although a drug can have specific origins in one culture, it can be adopted and in some ways translated quite easily into different settings, with potential adaptations and differences. But perhaps most importantly, it shows quite succinctly that, even under adverse circumstances, individuals still seek a means of enhancing or changing their consciousness by using mood-altering substances. Indeed, a harsh environment may be made bearable by reliance on such drugs, as in the case of coca in the Andes.

In the context of this thesis, the focus will be the investigation of what drives individuals to take drugs and become addicted. In particular, the concept of alienation as a potential cause of substance abuse will be investigated. The above paragraphs have already alluded to the role culture plays in the procurement and consumption of drugs. By investigating a Middle Eastern cultural context that is vastly different from those contexts that most research studies draw on for their generalizations and observations, this study hopes to shed light on the issues of being addicted, being alienated and being able to cope with adverse circumstances.

The thesis consists of six chapters. In chapters one and two, I provide an overview of the literature on addiction, alienation and assertiveness, culminating in a theoretical framework that supports a

quantitative investigation. Methodological issues are discussed in chapter three, and results are presented in chapter four. Because of the findings, it was decided that a different study of a qualitative nature needed to be conducted in order to shed light on the findings, and indeed to revisit the core concepts of the thesis. Chapter five details of this study. Chapter six provides a general discussion and critical reflection on the thesis.

CHAPTER ONE: ADDICTION

1.1. INTRODUCTION

“How a society views individuals who engage in addictive behaviours has an important influence on addiction and recovery from addiction. If addiction is seen as a moral failing, it will be condemned. If seen as a deficit in knowledge, it will be educated. If the addiction is viewed as an acceptable aberration, it will be tolerated. If the addiction is considered illegal, it will be prosecuted. If viewed as an illness, it will be treated”, DiClimente, (2003, :vii).

DiClimente’s view illustrates how, seen through different lenses, addiction elicits various responses. Throughout history, shifting frameworks of meaning have been applied to addiction, influenced by moral, legal, scientific, political and geographical factors. In this chapter, my aim is to give an account of addiction drawing on a number of these factors. I will start by reviewing some prevalent medical definitions, since these have a general, global relevance, as they are used internationally in medicine and indeed influence international legal frameworks. Because a main aim of the thesis is to explore addiction within both a UK and Saudi population, I will examine the historically complex relationship that East and West have experienced in terms of drug use, and will highlight some of the obstacles in researching across cultures. Further, I will draw attention to some political events that have shaped the landscape of drug use globally, before turning to the specific contemporary situation in terms of policy and prevalence in both the UK and Saudi Arabia. Following this, I will review some of the models and theories that have at different times been influential in understanding and explaining addiction, before presenting the position this thesis will assume.

1.2. DEFINING ADDICTION

Addiction is by no means a homogeneous entity; it is not surprising, then, that there are almost as many theories of dependence and its causes as there are types of dependence behaviour. The Oxford Companion to the Mind defines addiction as “a tendency to excessive use of the drug, a craving for it when it is not available, and the development of a variety of physical and psychological symptoms when it is suddenly withdrawn” (Oxford Companion to the Mind, :4). This definition is, however, only one interpretation; addiction is a concept, which is notoriously difficult to define, so much so that the World Health Organisation (WHO, 1970) now uses the term “drug dependence” instead. Drug dependence is characterised by “psychological symptoms such as craving and a compulsion to take the drug on a continuous or periodic basis, and physical effects developing when the drug is withheld or unavailable”. (Oxford Companion to the Mind, :.4).

The difficulties in defining the essential characteristics of drug dependence are illustrated by the changes that have taken place in the last three decades or so. At one time, drug addiction and drug habituation were recognised as separate entities, with the former being more severe than the latter (Ghodse, 1990). They were distinguished on such grounds as the intensity of desire to take the drug, the tendency to increase the dose and the detrimental effect on the individual and/or society. Thus, some drugs were described as habituating and others as addictive, and one individual might be considered addicted to a drug whereas others were merely regarded as habituated to the same drug. Such terms are impractical, according to Ghodse (1990), particularly for application internationally, hence the advent of yet another (refined) definition of drug dependence: “A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterised by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience psychic effects, and sometimes to avoid the discomfort of its

absence. Tolerance may or may not be present” (Ghodse, 1990 :3).

According to Schweighofer (1999), the word ‘addiction’ has too many meanings. Partly, this is attributed to the fact that it contains a fundamental ambiguity. The term ‘addiction’ can imply both a positive and negative connotation, depending on the value attributed to the activity in question. Schweighofer argues that the main shift in the accepted meaning of addiction occurred in the nineteenth century. Addiction ceased to denote pleasurable but harmless activities (taking opium, for example), and became employed to refer to involvement in harmful practices, in particular with regard to drugs that could create tolerance or withdrawal problems. Arguably, the earlier meaning of addiction, from the Latin ‘addicere’ (to give over), is less inherently pejorative, as it has both a positive and negative potential. This is particularly true as the linking of addiction with drugs only occurred in the context of anti opium political rhetoric, and hence was not motivated by the findings of systematic research. It remains a meaning-shift that could be regarded as highly emotive. As Anderson (1980) suggests, with reference to heroin users, the contemporary formulation denotes “dependence, enslavement and compulsive use of a drug” (:5).

The more specific medical and psychiatric definitions, which influence heavily the diagnosis of individuals, can be found in DSM-IV (American Psychiatric Association, 2000) and ICD-10 (World Health Organization, 1992). The DSM-IV definitions differentiate between use, abuse, and dependence. Use refers to the taking of a drug, irrespective of the level of use. Use only focuses on the taking of drugs, without consideration of the effects of these drugs. When problems arise from any type or level of use, abuse is involved. Dependence involves impaired control over use, irrespective of the actual quantity or frequency of use or level of harm. The diagnosis centres on identifying “a maladaptive pattern of substance use, leading to clinically significant impairment or distress as manifested by three or more of the following

occurring at any time in the same 12-month period:

1. Need for markedly increased amounts of substances to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount of substances.
2. The characteristic withdrawal symptom is to take more substances to relieve or avoid withdrawal symptoms.
3. Persistent desire or one or more attempts to cut down or control substance use.
4. Important social, occupational, or recreational activities given up or reduced because of substance use.
5. Using more or over longer periods than intended.
6. A great deal of effort spent in activities necessary to obtain substances, use, or recover from their effects”, (DSM-IV :197-198).

ICD-10 differentiates between ‘harmful use’ and ‘dependency syndrome’. The former is defined as follows:

“A pattern of psychoactive substance use that is causing damage to health. The damage may be physical or mental. The diagnosis requires that actual damage should have been caused to the mental or physical health of the user. Harmful patterns of use are often criticised by others and frequently associated with adverse social consequences of various kinds. The fact that a pattern of use of a particular substance is disapproved of by another person or by the culture, or may have led to socially negative consequences such as arrest or marital arguments, is not in itself evidence of harmful use. Harmful use should not be diagnosed if the dependence syndrome is present” (ICD-10 :74). The latter is defined as follows:

“A cluster of physiological, behavioural and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (sometimes strong, sometimes overpowering) to take psychoactive drugs. There may be evidence that return to substance

use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals”, (ICD-10, :74-75).

1.3. EAST AND WEST: AN HISTORICAL CONTEXT FOR HEROIN ADDICTION

The juice from the white poppy, *papaver somniferum*, has a history of medical use dating back almost 6,000 years. Up until a century and a half ago, opium stood alone as one of the few agents physicians could use and from which they could obtain sure results. It relieved pain, induced sleep and corrected dysentery. Its recreational use also has a long history. The written story of opium begins 4,000 years before the birth of Christ with a reference to the ‘joy plant’ on a Sumerian tablet. The resinous raw opium, which is collected from the poppy seed pods in the brief period between the time the petals drop and before the seed pod matures, is the basis for the opium medicines used throughout history and is the substance from which morphine is extracted and then heroin derived.

Throughout history, opium has crossed geographical and political boundaries. For instance, the opium wars between Britain and China were less concerned with addiction but more with political sabotage. Psychoactive substances in general were unregulated, and their prohibition, approval or use depended on a variety of factors. For instance, opium was desired in China because the Emperor abhorred tobacco, and it was seen as a substitute. The political events which accelerated the use of morphine were wars: the American Civil War (1861-1865), the Prusso-Austrian War (1866) and the Franco-Prussian War (1870). The percentage of veterans returning from these wars who were addicted to morphine as a result of being given large doses medicinally was so high that the illness was called the ‘army disease’.

In contrast to the 19th century, when drugs were unregulated for the

most part, legislation to control drugs increased in the 20th century. Szasz (1987) contends that drugs served as a convenient scapegoat for the social ills of urban life. He observes that a double standard was used in setting drug policy. For instance, he suggests that because alcohol and tobacco are so well ingrained in Christian and English-speaking cultures, we regard them as good, but drugs such as heroin and marijuana, which originate from foreign countries, are viewed as bad. He illustrates this by considering the different labels and terms used in connection with legal and illegal drugs: people who sell alcohol are retail merchants, not pushers; people who buy alcohol are citizens not 'dope fiends'. The same applies for tobacco, coffee and tea, although the situation regarding tobacco has changed somewhat in the twenty years since Szasz postulated his views.

What can be concluded from this is that for many of these psychoactive drugs, there is a moral and political choice to be made regarding what is appropriate or not, good or bad. Drugs in and of themselves do not define acceptability – this is context dependent. Equally, how the user of different drugs is viewed will depend on a variety of factors, medical and social, and also moral. We will now review some aspects of this in both a UK and Saudi context.

1.3.1. Drug Use In The UK

It is beyond the scope of this thesis to give a comprehensive history of drug use in the UK, as this has been reported elsewhere (Jung, 2001). However, it is worth noting that some important shifts have taken place from how substance use has been viewed and treated in the past, to how it is dealt with now. Starting with the temperance movement, the notion of substance use (alcohol in particular) saw for the first time the linking of disease with morality in this context. As Levine (1984) reports, using alcohol excessively was first regarded as a sin (the choice to be drunk repeatedly), and then as a disease. These contrasting views survive in approaches such as the Twelve Step therapeutic programme. The main

recent, comprehensive report detailing the prevalence of drug use and treatment is the Drugscope Report to EMCDDA (2001; additions 2003). Its remit is to provide statistics regarding drug use in the UK, and monitors the 1998 UK Government 10-year anti-drug strategy 'Tackling drugs to build a better Britain'. The report estimates that 143,000 people are at risk of death due to drug overdose, between 161,000 and 169,000 have injected drugs, 202,000 are regular or sporadic opiate users, and 266,000 are problem drug users.

In the UK, a total of 40,200 persons sought treatment for drug use in the six month period ending 31st March 2003. This represents a 3% increase on the same period in 2001, but a decrease of 6% on the same period in 2000. 38% of users were known to inject their drugs; most cases being reported were opiate users, 77% also reporting heroin to be their main drug of use. This is consistent with data from previous years (1995; 1999; 2000). The main changes in the values of heroin indicators (deaths, offences, seizures and treatment) are that all these indices show a marked increase, viewed over the period 1993-2000. Numbers nevertheless remain relatively low when compared to other drugs, notably crack and crack cocaine, over which there has been increasing concern.

In terms of drug treatment, the National Treatment Agency was launched in April 2001, and it oversees the process of establishing and disseminating national standards for commissioning, delivery and monitoring of drug treatment services. In the UK, there are three main categories of services, which will be briefly explored below: drug-free treatment, substitution and maintenance programmes, and after-care and reintegration programmes.

Drug-free treatment services are abstinence based and have relapse prevention as their major service outcome goal. The existing network consists of a combination of early intervention practices, advice and

counselling and out-patient services. The majority of residential rehabilitation programmes require clients either to be 'drug-free' on entry and/or to have achieved a state of abstinence from their main, or all, problem drugs, or to undertake an on-site detoxification from drugs and medication. Admission is voluntary and there are no priorities groups for drug-free treatment as there are for substitution treatment programmes. These programmes usually run from immediately after the completion of detoxification and last between three and twelve months. Theoretically, the approaches identified as most effective by the Task Force to Review Services for Drug Misusers (1996) are cognitive behavioural approaches, 12-step addiction counselling, and other psycho-social approaches including gestalt and family therapy. To accomplish relapse prevention they provide a safe living environment supported by staff and peers and a therapeutic programme comprising groups, lectures, individual counselling and family involvement. Outcome evaluation is mixed, with most treatment evaluation conducted internally by the services involved and rarely published. A report to the Home Affairs Select Committee by NHS Alliance special advisor (2001) states that in some of these programmes, drug users are being treated by GPs who lack training, resources and remuneration.

Substitution and maintenance programmes support medically supervised withdrawal. The overall aims of substitute prescribing, according to the Department of Health (1999), are: to assist the service user to remain healthy until, with appropriate support, he or she can achieve a drug-free life; to stabilise the service users, where appropriate, on substitute medication to alleviate withdrawal; to reduce the use of illicit or non-prescribed drugs; to deal with problems related to drug misuse; to reduce the dangers associated with misuse, particularly the risks of HIV, hepatitis B and C and other blood-borne infections; to reduce the duration of episodes of drug misuse; to reduce the need for criminal activity to finance drugs, to reduce the risk of prescribed drugs being diverted onto the illegal drug market; to improve the overall

personal, social and family functioning. The majority of clients entering prescribing programmes are dependent heroin users who present with additional polydrug use (DoH, 2002a). Admission is voluntary, but usually by GP referral or criminal justice referral. Priority is given to those who are HIV positive or with other severe physical co-morbidity, those with mental health co-morbidity, pregnant women, and young people, particularly when deemed vulnerable. At times, other locally defined groups may also be prioritised. Most prescribing in the UK is for oral methadone, although some 10% of prescriptions were issued for injection. Diamorphine is only rarely prescribed in the UK. Codeine-based substitutes, particularly dihydrocodeine, are used by some clinicians. Buprenorphine is also licensed for substitution treatment, and lofexidine is prescribed for community detoxification programmes. Those who have completed opiate withdrawal but need pharmacological assistance to remain drug-free can have maintenance treatment with the opiate antagonist naltrexone. In addition to substitution drugs, there is also the provision of psycho-social counselling, with the same main three theoretical foundations as employed in the abstinence programme (Cognitive behavioural; 12-step; gestalt and family therapy). Most often, brief interventions, cognitive behavioural and motivational interviewing are employed. This is currently the main form of treatment programme in the UK (Department of Health, 2002a). Gossop, Marsden and Stewart (2001) and Gossop, Marsden, Stewart and Treacy (2002) showed that overall significant improvements were made in drug-related problems, health and social functioning amongst those attending methadone programmes. In particular, reduction rates of non-fatal overdose were recorded, and these were linked to improvements in frequency of drug use and lower rates of injection, sharing needles and having unprotected sex.

A third strand of programmes consists of the reintegration and after-care programmes; this differs from the above two strands in that the focus also includes how to reintegrate once the formal treatment

programme is concluded. About 70 such programmes are operating in the UK, with some 1200 beds available. There are three types of programme: short-term residential rehabilitation of three months, long-term rehabilitation for up to six months plus, and primary/secondary treatment split. Most rehabilitation provides a structured programme with the following basic features: maintenance of abstinence from illicit drugs in a controlled or semi-controlled therapeutic environment; communal living with other users in recovery; emphasis on shared responsibility through peer and group counselling; relapse prevention-oriented counselling and support; individual support and promotion of education, training and vocational experiences; improved skills for daily living; housing advocacy and resettlement work and aftercare and support. The reintegration of chronic drug users was an essential component of the 1998 Drug Strategy. No formal evaluation is reported.

What kinds of ideologies can be discerned in these treatment programmes? Firstly, the strategy has multiple strands rather than relying on a 'silver bullet' approach. It is acknowledged that drug users are not a homogeneous group, and therefore a variety of treatment plans are on offer. While methadone prescription has been regarded as controversial, particularly in the US (DiClemente, 2003), outcome studies do suggest that it is an effective treatment in reducing (if not eradicating) heroin use.

Secondly, a core part of the strategy is that drug use should not be regarded in isolation. The Drug Strategy has been linked to the New Deal, which allows a refocusing on the hardest to help and the most vulnerable. The New Deal programme provides financial support, promotes an active labour market policy to increase equality and opportunity, and aims to support participants in gaining the self-confidence, experience and skills, which will increase their employability. To get on the programme, participants will need to be drug-free. The rationale for this is that certain groups are socially

excluded, and the evidence suggests that social exclusion is interwoven with drug use. Substance misuse is reported to be particularly high among groups who suffer from other forms of deprivation, including rough sleepers and vulnerable young people (Goulden and Sondhi, 2001). In short, there is a high correlation between social vulnerability and chronic drug use. The causal linkages are not understood, however, and remain a matter of speculation (Eggington and Parker, 2000). The emphasis, then, is on integrating drug users back into mainstream society through a combination of drug treatments, skills training, and employment opportunities. It is hoped that through this approach, the side-effects of drug use such as crime rates will also be reduced, thereby contributing to a cohesive and inclusive society – joined-up solutions to joined-up problems.

1.3.2. Drug Use In Saudi Arabia

Baasher (1981) described the development of the early Islamic community and the control of alcoholism within the context of overall socio-cultural changes. In his paper, he highlights two interesting facts. Firstly, taking an historical perspective, the brewing of alcohol was generally popular among pre-Islamic communities. However, at the very beginning of the Islamic era, the drinking of wine was clearly identified as a disruptive social evil and was effectively dealt with by using step-by-step methods, which were applied to attain acceptance of prohibition. After fourteen centuries, the successful Islamic model of alcohol abstention and prohibition still stands out as exceptional, indeed, almost unique, in human history. In his paper, Baasher (1981) raised some interesting questions. Although Islamic teachings clearly succeeded in persuading early Islamic societies to give up the use of wine, to what extent had this been observed over the years, and is it still observed within the Islamic world today? And, how effective is the Islamic way of shaping human behaviour in preventing the abuse of drugs among changing Muslim communities? Baasher's results showed that despite the socio-economic differences and varying cultural heritages among

diverse Muslim countries, the practice of the Islamic doctrine was considered the most essential factor in maintaining a relatively low prevalence rate of alcoholism in the population of these countries compared with other parts of the world. As with alcohol, the Islamic law clearly stipulated that whatever constitutes a dependence-producing drug (and should therefore be regarded as harmful) should not be used by a true Muslim. However, it was clear from the available data that the nature and extent of drug-related problems varied from one Islamic country to another. While the strong movement against alcohol has generally continued in the Islamic World, the history of the use of other dependence-producing substances in the various Islamic countries has been somewhat varied and complex. Availability of the drug concerned, the socio-cultural environment, economic conditions, political power and a host of other factors have in one way or another influenced the spread and the control of dependence-producing drugs. Studies of opium use in Pre-Revolutionary Iran and parts of Pakistan have shown that a drug culture has been accepted in these countries with local social approval. Here it seems that there is a complete disregard of Islamic precepts regarding the 'sinful' and harmful social consequences of narcotic substances as perceived in other Islamic countries.

Nonetheless, serious attempts were being made towards a visible breakthrough in the battle against the drug problem in Iran and Pakistan. Baasher (1981) concluded that although both Iran and Pakistan were endeavouring, in principle, to comply with Islamic doctrine, they would not find a better model than the one which was first implemented at the dawn of Islam at Medina, where due consideration was given to the prevailing ecological factors and a step-by-step system of gradual desensitization, persuasion and effective community involvement was applied (Baasher, 1981). It is important to note, however, that Baasher's findings refer to Pre-Revolutionary Iran.

In 1992, Qureshi carried out a preliminary study to evaluate the

demographic parameters, pattern and co-morbidity of drug abuse among 120 Saudi male mental health patients. The results showed that the relationship between socio-demographic variables and drug abuse is not straightforward. Nonetheless, this controlled study identified some significant association between drug abuse and marital problems, being unemployed or in an unskilled job, or from a poor social class, thus substantiating the results of other research. However, the study had some limitations that precluded the author from generalising the results of this study across Saudi society. For example, the selection of patients was biased (non-random amongst the chosen population) and the control group might not have been representative of the general population. Three years later, Hafeiz (1995) conducted a preliminary study of the socio-demographic characteristics and pattern of substance abuse in the eastern region of Saudi Arabia. He stated that there was evidence, though scant, that drug abuse was more common in Saudi community than was previously thought. His conclusion was that it seemed that a pattern was gradually emerging among Saudi drug abusers, characterised by variation in drugs abused and the increasing problem of heroin that affected about 50% of the cases, despite the many religious and cultural deterrents. This pattern seemed to have many common features with the reports of drug abuse abroad by Saudis, especially in relation to heroin and alcohol.

In a study by Al-Delaim and Abdullah (1997), it was concluded that the management of substance abuse was a new and unique experience in Saudi Arabia. The establishment of large drug addiction hospitals, the application of religious beliefs in dealing with drug addicts and the strict measures applied to psychotropic prescriptions were some of the unique features of the Saudi model. Qureshi and Al-Habeeb (2000) examined drug abuse patterns in psychiatric populations in Saudi Arabia. They concluded that drug use, addiction and associated problems are present in Saudi Arabia and that parents can play a key role in drug prevention through controlling the money supplied to children.

Whether or not drug abuse is more common in the Saudi community than was previously thought is not clear. It seems likely that the nature and magnitude of the drug problem has changed and might still be changing. Further studies are no doubt needed in the Muslim/Arab communities before final conclusions on the nature and magnitude of the drug problem can be reached. The reason why drug use and the behaviour of the drug market is changing in Saudi Arabia is unclear, but could be due to socio-economic changes, better transportation or greater drug availability. Even though Baasher (1981) came to the conclusion that the prevalence rate was still low compared to other parts of the world at that time, he mentioned that the drug scene had witnessed a colossal increase in manufactured chemicals and the build-up of new drugs. With increased productivity and closer relationships between industrialised and Islamic countries, more and more synthetic drugs are becoming available for public use.

Providing statistics for heroin use in Saudi Arabia is problematic as, for a long time, records (if kept comprehensively) were not readily available in the public domain. No data is available regarding treatment for heroin users. However, unpublished data obtained from the Interior Ministry give some indication of the scale of drug use within the Kingdom. Data are available for the period 1989-2004, showing the number of drug users who have been arrested, and the amount of drugs seized by the Ministry. These data can be found in Appendix Twelve. In 1998, the number of drug-related arrests was 5,777, rising to 35,440 by 2004. Unfortunately, it cannot be discerned from this data how many of these arrests were heroin-related. Furthermore, the increased number of arrests may merely reflect more active policing, a change in policy or the implementation of policy. The quantity of drugs confiscated does indicate however that the amount of heroin seized is relatively stable, with 52,839g seized in 1989 and 61,504 in 2004 (rising to 119,464g in 1996). Larger increases can be observed for cannabis, amphetamines and khat, which may also indicate that heroin use has remained more or less

stable.

The main treatment programmes focus heavily on what is called religious therapy, which is based on the application of the Quran. The Holy Quran states:

“They ask you concerning wine and the game of hazard. Say: ‘In both there is great sin and also some advantages for men; but their sin is greater than their advantage’. And they ask you what they should spend. Say: ‘what you can spare’. Thus does Allah make His commandments clear to you that you may reflect”, Sura Al Baqarah, Sura 2, Verse 220.

The word translated as ‘wine’ can be used for anything addictive, and from the interpretation of jurists throughout Islamic history, it is clear that all forms of drugs are meant. Both substance use and gambling are linked in this verse, and both are considered *haraam* or taboo. Drug users are led back to this verse in the Quran, and are told to follow the advice of Allah and turn to Him and beg His forgiveness and ask for His guidance. They are told to embrace a new-found idea of trust (*tawakull*) in Allah, which becomes the driving force that fuels the recovery process. The vacuum in the addict’s life is thus purported to be filled, and the rebuilding of coping skills and social networks is found in the learning of Islam. It is posited that due to the compulsive nature of drug addiction, addicts may have behaved in an inappropriate manner, leaving them feeling guilty, exposed and ostracised, and it is considered that this can prevent them from mentally moving on and reintegrating into society. Addicts are quoted verses from the Quran such as “and whoever does evil or wrongs himself but afterwards seeks Allah’s forgiveness, he will find Allah Oft-Forgiving, Most Merciful” (4:110). Sayings of the Prophet Muhammed (s)¹ are also used, for example: “Whoever says

¹ (s) always follows the name of the Prophet Muhammed (s). It is an abbreviation for ‘sala Allah aleah wa salam’, which means ‘God pray for Him and give Him peace’ ‘peace upon him’.

'Subhan Allah wa bihamdihi' one hundred times per day will be forgiven all his sins even if they were as much as the foam of the sea". These strategies are designed to help addicts regain Allah's acceptance. Many others are quoted in the literature on the treatment of addiction. Another important role that Islam plays in recovery is through its social organization, where a great deal of emphasis is placed on togetherness (*jumm'ah*) and regular meetings for worship. This fulfils a number of purposes. Among these are learning to interact and relate to others as well as exchanging life experiences. For the addict, this social meeting becomes a stepping stone towards gaining social acceptance and integration into society. Further, invitation (*da'wah*) to others to adopt the way of Islam is also promoted. This encourages people from various parts of society to become actively involved in charitable Islamic activities in their local community. Essentially, this becomes a way of putting back into the community that which has been taken out. This engagement helps addicts develop a network of social support and participate in community development initiatives. This also inspires them to become organised and to learn new life skills, leading to changes in cognition, emotion and behaviour.

Western psychotherapeutic ideas are incorporated within religious therapy. However, they are adapted to ensure that they conform in theory and in practice to the prevailing religious beliefs.

The ideology behind the rationale for religious therapy is in fact remarkably similar to Western approaches. Twelve step programmes and community reintegration to a certain extent draw on the same principles of handing over power to a higher being, offering support while challenging certain patterns of thought and addressing emotions such as guilt, and attempting a reintegration into society – albeit without the explicit religious focus. No conclusive outcome studies of religious therapy have been conducted. One study (Iqbal, 2001) does however describe some problems with inpatient drug users in Jeddah. Iqbal

reports that very few drug users complete the programme, as they are dropping out after the detoxification phase. This results in a vast majority (87%) being readmitted within one year of discharge. Only 7.6% finished the whole treatment programme. Iqbal points to failures in the system of rehabilitation provision, and argues that compliance with the programme could be increased by initiating contractual treatment, and a further decentralisation and development of local services. Government regulations do allow drug users up to four voluntary admissions, with further treatment being compulsory in a secure Ministry of Interior unit for a fixed duration. Iqbal (2001), in an attempt to increase the effectiveness of the voluntary programmes, argues that the programme may need to change to ensure regional cultural acceptability; for instance, for some patients the duration of the programme was unsuitably long. Other reasons he points to for the high dropout rates are the lack of motivation for change, even though patients are fully aware of the Ministry of Interior legislation, and are aware that compulsory treatment could be made by special order, with family, police, court or employers in a position to make probation requests.

1.3.3. Ethno Cultural Difference And Drug Use

Studies within the drug research literature can take several forms. Some studies examine a single ethno-cultural group while others compare two or more different ethno-cultural groups. Some also consider different ethnic groups within the same country or compare different cultural groups between two countries (Adrian, 2002). The overall aim of most of these studies is to describe and compare drug use between different ethnic and culture groups. While the purpose of some of the studies is to understand how different racial and ethnic groups vary with respect to demographic factors, in order to better address their treatment needs, the purpose of others is to examine risk factors that discriminate between drug users and non-drug users with respect to culture, gender, age, and other demographics.

Because of these divergent aims, it is hard to compare these studies to find out whether drug behaviour is different between cultures and whether there is even a clear pattern within each group. However, in eleven out of the twelve studies considered here, there was a statistical difference between the groups examined, varying from factors relating to current drug use, reasons for starting to use drugs, and relationships with family and friends, to types of drug used, employment status, and age at which use began. These studies all examined substance use from a multicultural perspective but differed substantially in the way they were carried out. Despite the difference between the purpose and structure of the studies, it seems apparent that there is a difference in the pattern of drug use between different ethnic groups.

This difference is multifaceted and difficult to explain in causal terms. Furthermore, patterns of drug use and drug behaviour change and are not constant over time. Opium use in the late eighteenth century was, for example, socially acceptable in central Asia, but was considered very harmful by 1970 (Kerimi, 2000). If drug use behaviour (prevalence rate, etc.) in a country is subject to rapid change, it is hard to find a constant pattern that distinguishes different ethnic groups.

To highlight further how difficult this task (of finding a pattern of drug use between different ethnic groups) can be, Warner *et al.* (2001) pointed out: “It is important to consider that some of the reported differences may be due to methodological features unique to each survey, including the mode of data collection and the years during which the studies were fielded”. This is indeed the claim we make in the present thesis. Furthermore, Petry (2003) claimed that the differences might be related to ethnic variations in the interpretation of what constitutes abuse or addiction. A good example is the fact that the use of marijuana and opium is traditional in India, tolerated in the Netherlands, but illegal in many other parts of the world (Adrian, 2002). Even though there might be a pattern, we might not be able to see it because of the way people

interpret their drug use. People from India might for example not interpret their drug use as problematic even though they are as addicted to it as people from Sweden, while Swedish people would interpret their drug use as problematic (Petry, 2003).

As was mentioned above, some research compares two or more ethnic groups within the same country. The problem with this is that some of the participants are born in the country and some are immigrants. A study by Nemoto *et al.* (1999) identifies patterns of drug use behaviours in relation to cultural factors among Asian drug users in San Francisco (Chinese, Filipino and Vietnamese). In this particular study, all of the Vietnamese participants were immigrants. The reason for some of the difference between the three groups might be attributable to that. Even though people bring their own cultural beliefs and behaviour with them, they are often affected by how people behave in the new country. This is further compounded if you are born in the country and your parents are trying to maintain their cultural beliefs within the home. Cardinal *et al.* (1986) indicate that by the third generation, the old world patterns have been replaced by the usual behaviour of the place of destination. However, this information might tell us that drug addiction is highly related to the culture you live in. In research by Ma and Shive (2000), it is concluded that certain types of drugs have higher frequent use by specific ethnic groups. This shows that it is necessary to conduct more research on specific drugs rather than drugs in general because we cannot necessarily generalise from the use of one drug to that of another.

Most of the above research has limitation in two respects. Firstly, the authors mention that the results should not be viewed as representative of the general population. The results were limited to the group examined, so generalisation to other groups could be made only cautiously, if at all. Secondly, since most of the research was based on questionnaires and interviews, there was also a problem with the accuracy of self-report measures. This again highlights the fact that, even though there is a

difference between the groups compared, it is very hard to use the information to find a clear and constant drug use pattern between different ethnic and cultural groups.

It seems intuitively likely that there is a difference between drug use and behaviour between different ethnic and cultural groups. However this difference is not straightforward and it is very hard to find a clear pattern when comparing different studies, even though they all examine substance use from a multicultural perspective.

1.4. MODELS AND THEORIES OF ADDICTION

There are numerous conflicting models and theories of addiction, and a system based on the conceptual framework proposed by Brickman (1981) to organise models of helping and coping has been suggested as particularly relevant in the area of addictions (Maisto *et al.* 1988). Using a framework that stipulates that the individual holds responsibility for both the creation and the solution of the problem, Brickman arrived at four categories of classification. He named the models Moral, Compensatory, Enlightenment and Medical, and argued that while the models are internally coherent, each model is in some ways not compatible with the others. In term of the moral model, individuals are viewed as responsible for both the development and solution of their problems and are expected to exert willpower to resolve them. The compensatory model sees individuals as not responsible for the development of their problems but responsible for the solutions. Under the enlightenment model, the individual is seen as responsible for the development of the problem but not responsible for the solution. Finally, the medical model views individuals as responsible neither for the development of their problems nor the solutions to them. The basic application of this model is the treatment of physical illness. The individual in essence is regarded as the passive recipient of help from the expert.

The Brickman (1981) system outlined above, while serving as a useful framework, does not satisfactorily solve the problem of classifying the theories or models of addiction. In addiction, the medical or disease model is seen by some as a metaphor and the current formulations of the model have as many psychosocial elements as biological factors. A more useful way of categorization might be achieved by taking aetiology as a starting point. Brownell and Fairburn (2002) have identified seven sets of models that account for addiction based on a specific addictive behaviour or a specific way of understanding the origins of addiction and how these develop. I will adopt their proposed model and a review is presented below. While the primary focus of interest in the present study is heroin addiction, I will where appropriate draw on the literature concerning use and abuse of drugs other than heroin in order to present a fuller picture.

1.4.1. Social/Environmental Models

The social/environmental perspective emphasises the role of societal influences, peer pressure, social policies, availability and family systems as mechanisms responsible for the adoption and maintenance of addictions. This perspective has many advocates, and substantial evidence has been presented for the role of environmental factors. For example, Kilpatrick *et al.* (2000) identified risk factors by telephone-interviewing participants about substance use, victimization experiences, familial substance use, and post-traumatic reactions. They hypothesised that familial alcohol abuse or drug use would independently increase the risk of all forms of adolescent substance use. Also, they argued that sexual assault, physical assault, and witnessed violence would increase risk of adolescent alcohol, marijuana and hard drug abuse/dependence and that these effects would be apparent even after the effects of demographic variables and familial substance use variables were considered. Significantly, this study found that both experienced and observed violence elevated the risk for past-year problem substance use; familial alcohol problems were also independently related to increased

risk of adolescent alcohol and hard drug abuse/dependence, but not to marijuana problem use.

Sutherland and Shepherd (2001) explored in detail the relationship between various social aspects of young people's lives and substance use and differences in the degree of influence exerted by the different social factors as a function of age. The results suggest that within this sample of English adolescents, there is a strong relationship between substance use and the social factors examined. Although there were differences depending upon whether cigarette, alcohol or illicit drug use was being modelled, logistic regression indicated that the social factors could be ranked in the following order of importance: concurrent use of alcohol and illicit substances, having been in trouble with the police, perceived poor academic performance and low future academic expectations, a lack of religious belief, coming from a non-intact family, favouring peer over family opinion and having been suspended from school. Many of these relationships were age-sensitive with substance use peaking at age fifteen. However, a particular problem with adopting a risk factor approach in this area is the question of the direction of causality, or cause and effect (Sutherland and Shepherd, 2001).

In identifying risk factors it is noteworthy that one of the main reasons why people start to use drugs is because of influence of friends/peers. Drug use is highly related to whether or not friends use drugs and whether youths believe their friends would discourage their use of drugs. When drugs are used, it is almost always with members of a peer cluster (Bachman, O'Malley and Johnston, 1984; Coombs, Paulson and Richardson, 1991; Swaim *et al.* 1993; Aziz and Shah, 1994; Sutherland and Shepherd, 2001). Aziz and Shah (1994) examined the differences between addicted and non-addicted university students on measures of home environment and peer relations. The results showed that addicts were under greater peer influence than the non-addicts.

Some proponents of the social/environmental model have concentrated on the more intimate environment of family influences as a central factor contributing to the onset of addictive behaviours. The family can indeed have a very important influence on whether family members start to use drugs and it can also motivate drug users to engage in treatment and/or affect the treatment outcome (Bachman, O'Malley and Johnston, 1984; Sutherland and Shepherd, 2001). McArdle *et al.* (2002) explored family structure and measures of family function in relation to adolescent substance use. Their findings suggest that living with both parents and the quality of the parent-child relationship are associated independently with the rate of drug use by young people. They concluded that both the quality of family relationships and the structure of families appear to be significant influences on youth drug use. Family influences support both a genetic, nature-based pathway of influences and a family interaction or family system, nurture-based path (Merikangas, Rounsaville and Prusoff, 1992). Steinglass, Bennett, Wolin and Reiss (1987) have also proposed a more indirect route of transmission of drug problems through the child's adoption or rejection of family rituals and traditions. A further idea is that family homeostasis acts as a regulatory structure in which the deviant addictive behaviours play an important role in individual and family functioning (O'Farrell and Fal-Stewart, 1999).

Turning now to the more macro-environmental aspects of these models, it may be argued that seizing large quantities of imported heroin should decrease its supply and hence increase its price. In research by Weatherburn and Lind (1997), the question of whether large-scale seizures of heroin influence its price and purity at street level was investigated. Their results indicate that there is no relationship between the price, purity or perceived availability of heroin and the amount of heroin seized. One explanation for this might be that the quantities of heroin seized are too small relative to the quantities being imported to exert much affect on heroin price, purity and availability. Another

question they sought to answer concerned the impact that arrests for heroin use and possession have on the rate of admission for methadone treatment. The results suggested that there is no relationship between the rate of admission to local methadone clinics and the rate of arrest for heroin use or possession. However, Weatherburn and Lind later retested the hypothesis that drug law enforcement encourages entry into methadone maintenance treatment, with different results (2001). Although keeping their relationship/family together emerged as the most important reason given by respondents for entering treatment, avoiding more trouble with police/courts was also rated by the majority of respondents as an important or very important reason for entering treatment. Therefore, drug law enforcement may have a role to play in heroin demand reduction; however its effects are not evident for all ethnic groups and the separate effects of contact with police, age and time spent in the heroin market remain unclear.

1.4.1.1. Problems With The Social Environmental Model

One of the biggest drawbacks of this model is that it is very contextually and historically specific (Robins, 1980). For instance, drug research from the twenties, seventies and nineties cannot really be usefully compared, as family structure, law and social relations were very different during these eras. Social influences and trends shift, as does the prevalence of different types of addictive behaviours; this undermines the usefulness of a social/environmental model as a fixed explanation of all addiction at all historical points in time. There is also the problem of level of analysis: in the wider population, social and environmental influences clearly make a contribution. However, they fail to comprehensively explain individual initiation or cessation. Nevertheless, acknowledging the contextual role of society and environment does at least shift the focus from being solely on the user, as some of the following models and theories do.

1.4.2. Genetic/Physiological Models

The concept of genetic vulnerability to drug addiction is supported by several familial, twin and adoption studies. Family studies show an increased rate of drug disorders among relatives of drug addicts compared with that among the general population (Duaux *et al.* 2000; Pickens, 2001) suggests that a family history of drug disorder is a strong risk factor for the development of drug disorders (Enoch and Goldman, 1999). However, the familial transmission of drug abuse is thought to be due to genetic as well as common environmental influences (Pickens, 2001), because family studies that support a substantial degree of genetic vulnerability for substance abuse cannot separate familial environment from genetic contributions (Duaux *et al.* 2000).

Pickens (2001) examined familial influences on drug abuse severity and treatment outcome. They concluded that common genetic factors might underlie both susceptibility to heroin dependence and response to therapeutic methadone treatment. The results were explained by genetic factors that enhance opiate response, which has the effect of increasing both susceptibility to opiate dependence as well as methadone therapeutic response. However, their findings were based on a family study, and family studies do not distinguish between genetic and shared environmental influences on a trait.

A few recent twin studies, mostly of small sample size, have explored the heritability of psychostimulant and opiate use; heritabilities from 0.11 to 0.45 have been reported (Enoch and Goldman, 1999). Twin data now provide significant support for the idea that drug abuse vulnerability displays significant genetic components, and appears to be more prominent in the more severe abusers and with some categories of drugs like heroin. However, the incomplete concordance in monozygotic twins demonstrates that environmental factors also play a major role in the development of addictive disorders (Duaux *et al.* 2000). Twin studies have established that the role of genetic variation in addictive disorders is profound; however twins with the same genotype often do not share the

same behaviour. This is likely to be due to other complex interactions, including the role of individualised environments (Enoch and Goldman, 1999). Despite being fewer in number, adoption studies demonstrate a significant genetic component to the heritability of substance abuse, and cannot be discounted (Duaux *et al.* 2000).

Over the past few decades, much work has been done to determine the genetic component of substance abuse, but the difficulties are great, and progress has been slow. In humans, case-control association studies have established a role for genetic variants of alcohol-metabolising enzymes in the predisposition to alcoholism; however, firm findings for the role of specific gene variants for other addictive disorders are not available (Enoch and Goldman, 1999). Segregation analyses suggest that a major gene is not likely to be operative in alcoholism or in other addictive disorders but that vulnerability to addiction and the disease pathology itself may be under the influence of many genes, perhaps on several chromosomes. The triggering of addiction may be influenced by interactions with multiple environmental components. Like most other common diseases, such as cancer, the addictions are complex in origin. The effect of volition, including choice of lifestyle, and of factors that act at the level of the whole community, such as the cost and availability of a drug, are salient. Yet vulnerability to the addictive disorders is strongly related to individual genotype (Enoch and Goldman, 1999).

Furthermore, studies have shown that while there may be a genetic predisposition to substance abuse, its existence does not mean that national or ethnic differences in drug consumption are also genetic in origin. A focus on the genetic contribution to addiction does not shed light on the factors contributing to the large geographical differences in heavy consumption of drugs. Neither do genetic differences help to explain changes in using behaviour over time, in terms of aggregate or individual consumption. A genetic predisposition is clearly not sufficient to account for addictive behaviour (Boymal, 2003).

Peele and Degrandpre (1998) also argue that addiction cannot be defined strictly in terms of the addicted organism and a chemical substance, and that drug problems can never be isolated from cultural and other contextual factors nor from the situation of the actor. In their article they review animal laboratory and human epidemiological studies to show that environmental factors ultimately determine drug use. They come to the conclusion that there is no disagreement between animal models of drug taking and naturalistic drug use: in both spheres all drug use depends on individual history and prevailing environmental circumstances.

The genotype-environment relationship is described by a term from quantitative genetic theory referred to as *genotype-environment correlation*: the extent to which individuals are exposed to environments as a function of their genetic propensities. These correlations are important in the study of psychopathology because they identify environments that may maintain the expression of underlying genetic liabilities for a disorder. Jang *et al.* (2001) in a twin study examined the correlation between genetic liabilities for alcohol and drug misuse with perceptions of the social environments of the family of origin and the classroom. The primary finding of the study was that pathological alcohol and drug misuse was correlated with decreases in perceived family moral-religious emphases, family cohesion, and classroom task orientation and increased perceptions of classroom order and organization.

Also, Pickens (2001) indicates that the genetic mechanisms underlying opiate and cocaine dependence appear to be fundamentally different. They point out that findings from a recent twin study (Tsuang *et al.* 1998) suggest that little genetic variance is shared between cocaine and opiate dependence, unlike between cocaine and other abused drugs. This again reminds us that it is necessary to conduct studies that only examine one specific drug rather than drugs in general. Whether a

common genetic vulnerability to addiction to different substances exists or whether susceptibility is individual to particular drugs needs to be determined (Enoch and Goldman, 1999).

There appears to be consensus that addictions are multi-factorial disorders that are genetically and environmentally influenced and that genetic vulnerability to drug addiction is complex, this difficulty being magnified by the role of environmental factors (Duaux. *et al.* 2000). Research into the genetic factor can be very important in number of ways. An informed understanding of the concept of genetic vulnerability can be especially valuable for the children of addicted people, who may use the information that they are at higher risk for addiction to make informed choices about sampling or avoiding drugs. And while the ostensible symptoms of addiction overwhelmingly consist of social or cultural transgressions, its underlying nature is generally located in one or another sort of bodily pathology, deficit or vulnerability. In view of this fact, addiction research can provide opportunities to explore empirically how our bodies are variously configured as causal forces under different social conditions (Weinberg, 2002). Further identification of vulnerability genes in drug abuse will be confronted with the importance of environmental factors in the phenotypic determination and with the difficulties of building models to study the interaction between genes and environment (Duaux *et al.* 2000).

1.4.2.1. Problems With The Genetic/Physiological Model

In all addictive behaviours there appears to be a role played by physiological mechanisms, and potentially by genetic factors in the behaviour's initiation, problematic long-term use, abuse and dependence. However, there are many questions and concerns about assigning sole causality or primacy to genetic/physiological factors (Newlin, Miles, van den Bree, Gupman and Pickens, 2000). Because so many different individuals can become addicted to so many different types of substances or behaviours, biological or genetic differences do not explain all the

cultural, situational and intrapersonal differences amongst addicted individuals and addictive behaviours (Cadoret, 1992).

A telling marker is also the change of definition in the DSM-IV, in that the distinction between abuse and dependency based solely on physiological tolerance has been practically eliminated.

1.4.3. Personality/Intrapsychic Models

Addictive behaviours have often been conceptualised as a symptom of more historical, intrapsychic conflicts. Proponents of this perspective point to the frequent correspondence between drug abuse and a diagnosis of antisocial personality disorder as evidence of drugs being a symptom of a larger psychological problem (Weiss, 1992). For instance, McAree, Steffenhagen, and Zheutlin (1969) found gross-multiple drug users in a college population to differ far more from non-users on MMPI clinical scales than did users of marijuana only. In fact, a high incidence of characterological problems among heroin addicts has been well documented (Berzins, Ross and Monroe, 1971; Sutker, 1971; Sutker and Allain, 1988). The marijuana group (in McAree *et al.* 1969) differed from non-users on only one scale, while multiple drug users differed on seven, including those for psychopathic deviation, hysteria, hypomania and schizophrenia. Overall they were more disturbed emotionally than either non-users or users of marijuana only. However, part of the difference in description may be due to differing perspectives: a clinician interested in the ‘premorbid’ personalities of illicit drug users and a psychometrician testing their present personalities might well disagree in their observation and conclusions. McAree, Steffenhagen and Zheutlin (1972) pose the question of whether the evidence of emotional disturbance is a function of drug use, or drug abuse a function of emotional disturbance, and claim, ‘intuitively’, to sense a strong relationship between “creativity”, college dropouts, emotional instability and drug use, even wondering whether drug use is the equivalent of dropping out of college for some students. They argued that drug use

and drug abuse should be considered discrete phenomena. On the basis of the MMPI, no major personality characteristic differentiated marijuana only users from non-users, but several scales differentiated the gross-multiple user from the non-user (however it was also true that some heavy drug users did not score as emotionally unstable on the MMPI pathology scales). One of the same researchers on the MMPI (Steffenhagen, 1974) suggested that the “marijuana user did not differ significantly from the non-user on scales of pathology but that the multiple drug user (marijuana and dexedrine) was distinguishable from the non-user to some extent and the gross-multiple drug user was clearly distinguishable” and concluded, “thus different drug usage patterns reflected different personality profiles”. (1974 :37).

Many other studies have shown narcotic users as having different character structures (from non-addicts), as well as demonstrating measurable differences on emotion profiles (Cox, 1985). It has also been shown that heroin addicts have significantly elevated scores on scale four (sociopathy) of the MMPI. “This suggests that addicts have at least a tendency to be more socially deviant than non-addict prisoners. Whether their sociopathy is a function of years of manipulating, stealing and conniving to acquire daily illicit drugs and to escape detection, or a precipitating factor in their becoming heroin dependent, is a problem for research” (Sutker, 1971 :167). Astin (1963) showed that equally high scores on scale four have different clinical implications, depending on the internal composition of contributing factors and Lykken (1957) differentiated primary and secondary sociopaths on the basis of manifest anxiety. Steffenhagen (1974) also claimed that self medication (i.e., taking drugs in order to feel normal) has been underestimated as a factor. This is corroborated by work on smoking, obesity, and alcoholism (Brownell *et al.* 1986).

However, Botvin (1986) suggested that while psychosocial factors appear to be primarily responsible for the initiation of substance use, as

use becomes more regular, psychopharmacological factors become increasingly important in reinforcing and maintaining regular patterns of use (Meyer and Mirin, 1979). Ray (1972). Mizner, Barter and Werme (1970) found, for instance, that while curiosity was the primary stated motive for initiating marijuana use, pleasure was the most frequently stated reason for continued use. There have been other similar findings (e.g. Goode, 1970; Keeler, 1969; Rouse and Ewing, 1972). Trice (1966) has floated the concept of the pre-alcoholic personality, suggesting that there may be pre-disposing personality factors, which could be a necessary but not sufficient condition for drug use to occur.

An overview of psychological models of addiction would not be complete without the inclusion of psychodynamic formulations and theories, because this perspective has influenced much of the thinking behind the psychological work carried out in clinical settings. It must be noted that this perspective is largely ignored in reviews and texts of addiction.

On the one hand, there have been minimal contributions from this perspective to the theoretical and conceptual developments in this field (Hopper, 1995). On the other hand, in treatment settings it has had, and still has, a large influence. This paradoxical situation is due to the domination of relationship-based models or philosophies of treatment in specialised treatment settings dating from the sixties and seventies. The assumption was that the addict will achieve abstinence through the process of a therapeutic relationship with a drugs worker. Counselling, which became the main intervention, was based on psychodynamic assumptions but was often carried out by individuals with little or no training in psychodynamic therapy. It could be argued that much of this work took place under a pseudo-Rogerian humanistic banner with little or no acknowledgement of the underlying psychodynamic processes. Like most other schools of psychotherapy at different times in their historical development, the humanistic counselling perspective has thus

far had little to say on the specifics of addictive patterns, and could be seen as having no identifiable model for addictions.

However, Rogers' (1951) concept of distorted symbolisation encompasses a broad range of ideas that indicate how the individual may acquire attachments to behaviours or items that are ultimately destructive to them, despite apparent early benefits in the individual's experience of them.

It can be argued that this approach may not facilitate change in addicted individuals, although Rogers' own early research findings were to the contrary (Rogers, 1961). The psychodynamic processes, such as transference and counter-transference, projection, projective identification and denial, which appear to dominate the counselling work that goes on in many addiction treatment settings, takes place without the supervision and theoretical framework such work requires. This lack of framework or clarity could account for much of the 'stuckness' that is seen in psychological work in addiction treatment settings and is arguably damaging to both client and counsellor.

The psychodynamic umbrella encapsulates a range of viewpoints or schools of thought. These range from the psychoanalytical school, to analytical psychotherapy, to transactional analysis. Theorising about the development and maintenance of drug addiction has largely come from the psychoanalytic school. The theory postulated by Hopper (1995) encompasses many of the previous theoretical formulations. Hopper (1995) suggests that the main cause of the addiction syndrome is the unconscious need to entertain and enact various kinds of homosexual and perverse phantasies and at the same time to avoid taking responsibility. It is hypothesised that specific drugs facilitate specific phantasies and using drugs is considered to be a displacement. Yet perhaps the most salient aspect of the theory is the link Hopper (1995) makes with traumatic experience. He argues that the addiction syndrome is also hypothesised

to be associated with life trajectories that have occurred within the context of traumatogenic processes, the phases of which include social, cultural and political factors, encapsulation, traumatophilia and masturbation as a form of self-soothing. Glover (1932), in Hopper (1995), claims that addiction is associated with primitive or 'psychotic' anxieties, and is therefore intermediate between the perversions and the psychoses. Also, he claims addiction to be based on a compulsion to obliterate internal objects, and not on a search for bliss in terms of a fixation in an oral stage of development. Much of this work has been treated with scepticism by mainstream researchers, in part based on the claim that psychoanalysis is a hermeneutic and is therefore deemed as 'unscientific'.

1.4.3.1. Problems With The Personality/Intrapsychic Models

Although it seems logical to assume a role for internal personality dynamics in the addiction process, the evidence to date does not fully support the existence of an addictive personality that will predictably and reliably result in development of dependence on any or all of the addictive behaviours. However, certain personality factors appear to contribute to the development or establishment of an addictive behaviour, and do account for some of the needed explanation for addiction (Nathan, 1988). The lack of evidence has been one of the most often quoted reasons to reject these approaches. However, it needs to be pointed out that this is a very broad and disparate field, and at times evaluation methods have been employed that are specific to one approach, but not to others. It is not surprising for instance that psychoanalytic theory does not hold up when evaluated under a positivist framework – very different assumptions underpin these approaches.

1.4.4. Coping/Social Learning Models

Under these models, addictions are considered to be the result of poor or inadequate coping mechanisms. Unable to cope with life stresses, addicts turn to their addiction for escape or comfort (Wills and

Schiffman, 1985). From their perspective, individuals use substances as an alternative coping mechanism and rely on their drugs to manage situations, particularly those that engender feelings of frustration, anxiety, anger or depression. Ability to cope with stress has been identified as a critical deficit area in many theories and models of addiction, in particular emotion-focused coping (Pandina, 1992).

The social learning perspective emphasises social cognition and not simply coping – this approach tends to focus more on cognitive expectancies, vicarious learning, and self-regulation as explanatory mechanisms for addictions (Bandura, 1986; Maisto, Carey and Bradizza, 1999). Derived from the principles of social learning theory (Bandura, 1977), cognitive psychology and experimental and social psychology, the ‘addictive’ behaviours model sees addictions as over-learned habits that can be analysed and modified in the same manner as any other habits (Marlatt, 1995). Taking substance misuse as an example, this model sees the development of the addiction taking place on a continuum, from experimentation, recreational use, problematic use, to dependence. The continual, excessive use and ‘loss of control’ marks the endpoint of dependence. According to this model, an individual’s position at each point on this continuum is governed by processes of learning. The determinants of addiction could include situational and environmental antecedents, beliefs and expectations, the individuals’ family history and prior learning experiences, the consequences of the addictive behaviour and social factors (Marlatt and Grodon, 1985). A key assumption in this model is that addictive behaviours are maladaptive coping mechanisms that have led to negative consequences for the individual in terms of health, social status and self-esteem. The key cognitive processes related to addictions are defined as self-efficacy, outcome expectations, attributions of causality and decision making (Beck, 1993; Marlatt, 1995). A number of models of addiction and interventions have been developed on the basis of these processes. For instance, Beck’s (1993) cognitive model describes addictive behaviours arising out of the

interplay between layers or levels of beliefs. Core beliefs or core schemas of an individual are activated by a critical incident, giving rise to cravings. These cravings in turn activate permissive beliefs to indulge in the addiction, subsequently leading to the addictive behaviour. Drug addicts (Callner and Ross, 1978; Cheek and Mendelson, 1973) also demonstrate a low level of assertive and social skills. Cheek and Mendelson (1973) conducted a series of inter-related studies which examined the relationship between level of social competence and interpersonal functioning of individuals with histories of psychiatric hospitalisations. The results of these investigations indicate a significant correlation between a patient's post hospitalisation success and his pre-morbid level of social competence. The social learning perspective also emphasises the role of peers and significant others as models. Advertisers who use sports figures to promote a product clearly employ social influence principles (Goldman, 1999).

1.4.4.1. Problems With Coping/Social Learning Models

These models have become quite popular among addiction researchers and clinicians (Wannigaratne, Unnithan and Strang, 2001). However, many successful business people and athletes who appear to have good general coping skills get ensnared by addictive behaviours. Generalised poor coping cannot be the only reason individuals become addicted (Schinke *et al.* 1991). This seems particularly true for people who engage in the behaviour because of the positive enjoyment effects and not simply the relief of problematic emotions (Orford, 1985). However, even if coping defects are not the critical reason for the acquisition of addictive behaviours, one important consequence of addiction is a narrowing of the addicted individual's coping repertoire. Coping, then, may be more important as a way to remedy the consequences of an addiction than as a contributor to its acquisition (Shiffman and Wills, 1985).

1.4.5. Conditioning/Reinforcement Behavioural Models

Reinforcement theory seems an appropriate explanation for the subtle physiological effects of substances as well as for drug seeking elements of addictive behaviours (Barrett, 1985). Reinforcement models have been used to understand the initiation of addictive behaviours as well as their stability, which makes them difficult to modify. These models focus on the direct effects of the addictive behaviour, such as tolerance, withdrawal and other physiological responses/rewards (Solomon and Corbit, 1977).

Pavlovian conditioning and its variations have also been used to understand addiction (Hinson, 1985). Equally, motivational theory views repetitive behaviours such as chronic drug misuse as changing the motivational system underlying that behaviour (West, 1991). The concept of habit strength based on conditioning theory is said to play a part here. This refers to the causal link between a stimulus which is a cue to an action and the subsequent action. It has been argued that it may involve the enhancement of synaptic connections in the automation of psychomotor skills (West, 1991). The action of the drug itself may act to distort motivation. Motivational distortion theories can explain why relapse and craving can occur in the absence of withdrawal distress and why it takes time for an addiction to form.

One of the most salient features of addiction is that with the increased motivational strength of drug related behaviour there is a severe attenuation of the motivational properties of other reinforcers: for example, food and sex. The disruption of the previous motivational hierarchy, where motivation towards behaviours essential for survival and well being become less important compared to motivation towards drug-related behaviour, has been termed motivational toxicity (Bozarth, 1990).

1.4.5.1. Problems With Conditioning/Reinforcement Models

There is substantial evidence for the role of conditioning and

reinforcement effects in addictions. However, models that use only these two principles to explain acquisition and recovery appear to have difficulty explaining all the phenomena of addiction and change (Adesso, 1985). Once addicted, even severe punishing sequences seem to be unable to suppress or extinguish the behaviour (Orford, 1985). Even after long periods of abstinence, extinction appears problematic under certain conditions – for example, women who stop smoking during pregnancy have the addiction reappearing after birth (Stotts *et al.* 1996). The conditioning/reinforcement models offer some insight into the creation of substance use problems and into situational cues that can promote relapse (Marlatt and Gordon, 1985), but they do not sufficiently explain the whole of addiction.

1.4.6 . Compulsive/Excessive Behaviour Models

The difficulty of stopping or successfully modifying addictive behaviours has led to the development of models that focus on the repetitive nature of addiction. Those who compare addictions to compulsive behaviours most often come from either analytic perspectives, where addictions are seen as reflecting deep-seated psychological conflict, or from a biologically based view that compulsive behaviours represent a biochemical imbalance reflected in brain neurotransmitters (Orford, 1985). Analytic approaches would envisage the solution to lie in terms of intrapsychic conflict resolution; the biological approaches would explore psychoactive pharmacological treatments to bring the addiction under control. The compulsive behaviour explanation argues that the compulsive behaviour, such as drug taking, is less important than the compulsive mechanism that somehow becomes attached to this behaviour (Schinke *et al.* 1991).

The excessive appetite model developed by Orford (1985) attempts to provide a psychological explanation for addiction outside the neuro-adaptation model. The fundamental premise of this theory is that an attachment or an addiction to a substance or an activity can be formed by

psychological processes rather than neuro-adaptation, tolerance and withdrawal as in psychobiological formulations (Orford, 1995). A structure for an alternative model has emerged from a study comparing drinkers with gamblers (Orford and Somers, 1996). This model suggests that processes involving three sets of factors (primary, secondary, tertiary) contribute to the maintenance of an addiction and are independent of psychobiological factors. According to the model, the primary factor is the incentive motivation-focus of positive rewards as opposed to avoidance of withdrawal distress. This could involve memories of past rewards (positive outcome expectancies). Evidence supporting this view has also come from research within the psychobiological framework where positive incentive seems to offer a better explanation for addictive behaviours than drive reduction (Bozarth, 1990). The secondary factors in this model, consistent with drive reduction formulations, are said to act to consolidate and strengthen attachment to an addictive object. New drives are set up as a result of strong and negative emotions associated with the addictive behaviour and are enhanced by the operation of cognitive defences (for example, denial and rationalisation) that prevent the person concerned from seeing his or her situation objectively. The tertiary factors in the model are described as factors associated with harm resulting from the excesses of the addictive behaviour (for example, loss of self respect, relationships and employment). This may set up a cycle or cause a further increase in addictive behaviour (increase of incentive value and addiction life style) or motivate attempts to change. A study which has operationalised this model and measured attachment across twelve areas (strong desire, preoccupation, acting against judgement, loss of control, non-social activity, acquiring money for the activity by special means, feeling addicted or dependent, feeling depressed or guilty as a result, being criticised by others, feeling the need to change) by use of a twenty-four item questionnaire found a very similar pattern of response between gamblers and problem drinkers (Orford *et al.* 1996). The same study investigated the relationship between this measure and that recorded by

an instrument that was developed to measure the severity of dependence (SADQ: Stockwell *et al.*, 1979) within a neuro-adaptational framework. Significant differences were found on all scales between gamblers and problem drinkers in a predicted direction. The psychological model outlined above appears to offer an alternative to the established neuro-adaptational model of addiction.

Ironically, evidence supporting psychological theories of dependence has come from biological research into neural networks and neurochemistry, particularly the neurobiology of craving. Evidence for opiates activating neural mechanisms affecting both positive and negative reinforcement processes has been found (Wise, 1988). The negative reinforcement process supports the avoidance of withdrawal theory and the positive reinforcement process supports the excessive appetite theory. The discovery of positive mechanisms also explains dependence in the absence of physical dependence (Bozarth and Wise 1984; Deneau *et al.* 1969). Biological animal studies of opiate addiction have concluded that reinforcing effects of opiates are temporally, procedurally, neuroanatomically and neurochemically dissociated from their physical dependence producing effects (Bozarth, 1994). This work also discusses the central role dopamine plays in the neurochemistry of addiction.

1.4.6.1. Problems With The Compulsive/Excessive Behaviour Models

Although the compulsive and excessive models share a number of common explanatory components, they can differ dramatically in their suggested treatments. The connection between the addictive behaviour and the psychological functioning of the individual is highlighted under these models, but both disregard some important elements (Donovan and Marlett, 1988). Compulsive models disregard the unique contribution of the various types of possible addictive behaviours, while the excessive model does not sufficiently explain how it underpins all addictions, and is not explicit enough about how the process might work (Donovan and

Marlett, 1985).

1.4.7. The Integrative Models

The most frequently cited critique I have offered for most of the above models is that they only account for or explain addiction in part. There are a number of approaches that have endeavoured to integrate various strands to give a more comprehensive explanatory model. For example, Jessor, Jessor and Finney (1973) have, in their formulation of social learning theory, attempted to articulate how cultural and social factors interlink with individual ones. Kohn and Mercer (1973) state that this theory is appealing in that it begins with a set of external social conditions and predicts whether deviant behaviour will occur. Subsequent work by Jessor *et al.* (1973) also demonstrated that the model worked well in predicting problem drinking among Italian-American youth in the Boston area. It did not work well, however, when applied to Italian youth in Italy. This suggests the operation of another variable: cultural conceptions of alcohol. Heavy alcohol use is defined as a means of escaping one's problems and frustrations in American but not Italian society. Variants of Jessor *et al.* (1968) social learning theory of deviancy have been applied to marijuana use (Jessor, Jessor and Finney, 1973; Sadava, 1971), as well as marijuana and psychedelic drugs (Davis, 1972). As Davis aptly pointed out, correlational findings cannot necessarily be interpreted as supporting such a theory: e.g. if alcoholics are found to be downwardly mobile as the model would predict, it is still unclear whether they drink because things have gone wrong for them, or things are going wrong for them because of their drinking. There is a need here for longitudinal studies, of which a few have been reported (Jessor, Jessor and Finney, 1973; Sadava, 1971). On a related point, Zeichner, Pihl and Wright stated that "one might hypothesise that there are many routes to drug abuse and, consequently, that there is not just one type of personality that is susceptible to addiction. Thus, low social skills, psychopathy, tempting environmental exposure, a high level of frustration, all may heighten the probability of drug abuse" (1977).

Another early attempt at integration was the work of Steffenhagen (1974), who describes changing social conditions which leave people feeling confused and unsure about their identity. Thus drug use is seen as a way of helping the individual cope with the intra-psychic stress produced by external cultural stress. As he points out, "The motivation to use drugs is based upon many interrelated factors: the personality of the individual, the cultural environment, the social setting, and individual attitudes" (Steffenhagen, 1974).

The most comprehensive model of integration is presented by Donovan and Marlatt (1985). They argue for the biopsychosocial model as an integration of biological, psychological and sociological explanations, stating that addiction appears to be an interactive product of social learning in a situation involving physiological events as they are interpreted, labelled and given meaning by the individual.

1.4.7.1. Problems With Integrative Models

Although the proposal of an integrative model arguably represents an important advance over the more specific, single-factor models, proponents of the biopsychosocial model and other integrative models have not sufficiently demonstrated how the integration of the various elements occurs. Without a pathway that can lead to real integration, integrative models often only represent semantic linking of terms, or at best a partial integration. As such it allows individuals to use an integrative term while paying only lip service to aspects other than their primary area of expertise (Schulenberg, Maggs, Steinman and Zucker, 2001). These authors also argue that to date, there has not really been a fully functional integrative model that explains how individuals become addicted and how the process of recovery from addiction occurs.

1.5. POSITION OF THE THESIS

Ghodse (1990) warns that while recognising that very different situations may share hidden commonalities, many theories seem to be

saying more about the viewpoint of the investigator than about the dependent state they attempt to describe, and as such cease to be helpful in getting to grips with the phenomenon of drug dependence at ground level. Hence caution ought to be exercised. Equally, the whole notion of integration needs to be examined. Having offered a comprehensive review of the various theories of addiction, a critique will now be presented, culminating in an argument for a fitting theoretical framework for this thesis. It is not possible to offer a concrete 'solution' to the dilemmas already raised in this review of the various addiction models. However, a stance needs to be assumed in order to provide a rationale for the current thesis. The argument presented here is as follows:

1. Many of the models of addiction are medical in nature. As such, they almost function in a 'technological' manner. In other words, it is assumed that by isolating a variety of symptoms, and by submitting these to some form of treatment, addiction will be contained and cured. Based on empirical research, there is in fact little psychological theory that allows an understanding of the nature of addiction itself – although theory is applied to dealing with its symptoms.
2. Viewing the human condition through a medical lens is reductionist – it reduces addiction to a set of symptoms, without taking a holistic view. While attempts have been made to go beyond this (for example, the biopsychosocial model of addiction), it could still be argued that in particular the social and psychological aspects of this model are not sufficiently broad, nor are they sufficiently integrated with the biological and medical aspects. In other words, the addict and his/her addiction is still not comprehensively contextualised.

3. The empirical foundation on which many addiction models are based are medical, psychiatric and psychological, which at worst means that what is investigated is a series of variables, at best an individual. It can therefore only go so far in accounting for how an individual experiences addiction, what this means to them, in a specific social, political and moral situation. Thus, different bodies of knowledge need to be brought into the equation, such as anthropological and sociological theory.
4. While psychoanalytic theories have received much criticism (in particular for their alleged inability to ‘cure’ addiction), their insights (particularly as expressed in the early Frankfurt School work) can be useful in constructing a theoretical framework at multiple levels of analysis.
5. A key concept that has not been fully explored in relation to addiction is the concept of alienation. Rather than focusing on disease in a solely individualistic way, the notion of alienation also embraces social, political and moral issues. Theoretically, it seeks answers to account for causality of phenomena from a broader spectrum. For this reason, this thesis will attempt to apply this more encompassing lens to the study of addiction.
6. Further, drug use as a coping mechanism to defend against this alienation will be explored.

In short, what I propose to integrate are elements of a socio-environmental, intra-psychic and cognitive approach in order to account for addiction in two cultural settings.

CHAPTER TWO: A THEORETICAL FRAMEWORK LINKING ADDICTION WITH ALIENATION AND ASSERTIVENESS

2.1. INTRODUCTION

“By alienation is meant a mode of experience in which the person experiences himself as an alien. He has become, one might say, estranged from himself. He does not experience himself as the centre of his world, as the creator of his own acts, but his acts and their consequences have become his masters, whom he obeys, or whom he may even worship”. Fromm (1974, :120).

In this chapter, the theoretical lens will be broadened to include the concepts of alienation and assertiveness. Specific emphasis will be placed on psychoanalytic insights. The role between these theoretical perspectives will be explored.

2.2. DEFINING ALIENATION

Alienation is a term that is frequently used to describe a sense of crisis. Alienation, in this sense, becomes a description of human suffering in all its vicissitudes. The concept has been in the eye of the storm of many a debate between political theorists, sociologists and psychologists alike. Its subscribers have, over the years, exhibited Lewis Carroll’s dictum by making it mean largely what they wanted it to mean, regardless of how scholars in their own or other disciplines had defined it previously. Srole (1956) suggested a continuum of ‘self-to-others’ as being the basis for this construct. Lichtheim (1979) traced the concept of alienation or “estrangement” back as far as the writings of Plotinus, whose doctrine of emanation postulated a progression from an ultimate

indefinable source or principle to a multiplicity of finite beings, matter being the lowest stage of manifestation, and the antithesis of the One. The term “*Entfremdung*” (which Hegel subsequently used) occurs in Middle High German literature, and “alienation” dates back through Middle English and old French to classical Latin. The Latin term was “*alienatio*” (belonging or pertaining to another). One of the principal Latin uses of the idea of alienation was in connection with property. In this context alienation means, ‘to transfer the ownership of something to another person’. It is to cause something quite literally to come to ‘*belong to another*’.

Hegel’s term “*Entfremdung*” may be translated as ‘self-alienation’, if it is borne in mind that he used it in a christological sense and context. For Hegel, alienation was an ontological fact, rooted in the nature of man’s existence in the world. There was an inherent dissociation between man as a subject and man as an object (that is between man as a creative subject seeking to be, and to realise himself, and as an object influenced and manipulated by others), so that man’s own creations stand outside him as alien objects: namely his mind and his consciousness.

This view was rooted in German Idealism and in a metaphysical perspective. The German philosopher Ludwig Feuerbach (1984) and Karl Marx (1844) transformed alienation into a secular and materialistic idea. The evil that was alienation was a product of specific forms of social organisation. In Marx’s writings, the idea of socialism is powerfully linked with the idea of alienation: under capitalism, man is alienated from his human nature. Although his labour upon natural objects produces the value of the finished goods, he does not receive this value. Instead, his labour is bought and sold according to its commodity value. Thus capitalism, by reason of organising human beings into classes (defined by their relationship to the means of production), produces antagonistic conflicts of interest between men. In this sense, “the game of alienation is played out under capitalism in the ghostly form of class

struggle” (Kaplan, 1976). According to Marx, the only way to escape alienation, and its consequent false consciousness, is by transforming capitalism into socialism. For Feuerbach, the source of alienation lay in the institution of religion: the myths of divine power were merely ways in which man projected his own humanity outside himself, locating his own capacities and sensibilities elsewhere. Overcoming alienation required a humanistic religion of man, not of God. It was Marx who then completed the secularisation process. He believed that it was man’s nature to realise himself in work, but this is denied to him by the economic system. The person will be alienated in a world turned upside down, where the worker becomes poor, whilst the rich owner is getting richer. Thus he believed the key problem was not in Hegel’s “dissociation”, or in Feuerbach’s “religion”, but was the alienated labour under capitalism. Work was forced, rather than spontaneous and creative workers had little control over the work process; the product of labour was expropriated by others to be used against the worker. According to Marx, alienation consisted of the fact that man did not fulfil his “species being” in work; the essence of man remained unrealised.

With the rise of sociology and the idea of “value-free” science, the disillusionment inherent in the acceptance of a situation is construed not as “estrangement” from a better, more whole world, but stoically, as a coming to terms with reality. This is paralleled in Freud’s late works, “The Future of an Illusion” (1962), and “Civilization, Society and Religion” (1965). Here Freud suggested that religion, as an expression of idealism about the nature and possibilities of humankind, is mistaken; that in order to ‘grow up’, we must put away these childish longings, and come to terms with the ‘fact’ that there are no answers, no salvation, no hope of perfectibility. For Freud and his followers, self-estrangement is seen to lie in the split between conscious and unconscious forces in the personality. The person is out of touch in the sense that repressed and unacknowledged desires motivate his/her behaviour.

Thus, the evolution of alienation progresses from a philosophical idea to a secularised scientific concept. In fact, the concept has undergone quite as many vicissitudes since it was appropriated in the name of the recurrent tension between a definition of it as a subjective state of individual consciousness, and a definition focusing on an objective condition of society. It is also partly due to the way, possibly because of this apparently intrinsic ambiguity, researchers used alienation to mean what they wanted it to mean, with predictably confusing results. Nettler (1957) argues that the application of the label 'alienated' is far from morally neutral, and in fact both evaluates behaviour and positions the evaluator: "Not merely the definitions, but also the evaluations of the alienated man, vary with what he appears to be estranged from, and how: if he is a foreigner to himself, this is usually "bad" although this may be called "good" if he loses himself in an approved manner as through religious ecstasy or art. If however, he is discomfited by his own society, this is called "good" or "bad", depending upon society, or the critic, or whether the estrangement leads to "creative insights" or to "immersion in the mass media". Maslow (1954 :71) went even further, and took the view that a degree of felt alienation, given the condition of modern life, is not a sign of pathology but of psychological health: it must be a characteristic of the fully functioning individual, at least in our society.

The turning point seems to have come in 1959, when Seeman published his classic paper offering an elucidation of the concept into a cluster of five sub-concepts, which formed the basis for research endeavour for the following twenty years. As Seeman (1959) remarks in the introduction to his paper, "a concept that is so central in sociological work, and so clearly laden with value implications, demands special clarity". He goes on to identify five logically distinct usages of the term alienation and then to operationalise each of these five usages into a form which can be applied empirically. These are: powerlessness, the expectancy or probability held by the individual that his own behaviour cannot determine the occurrence of the outcomes, or reinforcements, he

seeks; meaninglessness, low expectancy that satisfactory predictions about future outcome of behaviour can be made; normlessness, denoting a situation where norms are unclear as well as losing their regulative force; isolation, referring to the assignment of low value to goals or beliefs normally held in high regard by the established society; self-estrangement or self-alienation, describing an individual who carries out his daily routine without feeling it exemplifies or represents an extension of self. A sixth was subsequently added in 1972, cultural estrangement, which refers to a person being estranged from one's culture.

This effort to achieve conceptual and practical clarification has provided the framework, even if only to deviate from it, for most of the work on alienation which has been done since 1959, the subcategory of "powerlessness" attracting the most attention.

Utilising the concept of alienation has benefits and drawbacks: benefits in that it is rich in meanings, drawbacks in that its application is, more than is the case with most concepts, tangled up with value judgements of complex kinds. It therefore needs to be applied with caution, and the specific theoretical perspective that is adopted needs careful outlining.

2.2.1. Psychoanalysis and Alienation

While the term 'alienation' itself is not much used in the psychoanalytic literature, there have been several striking characterisations of disturbances of the self system which in fact describe a condition of 'alienation from the self'. A distinction was made by Harris (1971) between social alienation and self-alienation, the former referring to feeling alone or apart from others, the latter implying doubt about and search for identity. Karen Horney's (1950) work is an exception in that she did use the term "alienation from the self" (AFS), in discussing these phenomena, and saw it as central to the subsequent development of neurosis.

The alienated person is out of touch with himself as he is out of touch with any other person. He, like the others, is experienced as things are experienced, with the senses and with common sense, but at the same time without being related productively to oneself and to the world outside. Although the concept of alienation as Fromm (1963) sees it was new, it implicates economic, social and psychological dimensions as well. It extends and varies the philosophical concept which indicates lack of self-awareness, or false awareness, or the awareness short of identifying one's characteristics, deeds and acts existing in the world outside. As man lives in the outside he, in his immature awareness, is isolated from himself. Rosenthal (1983), in his paper 'On Early Alienation From The Self', likewise emphasised the crucial role played by self-alienation in the development of neurosis and placed the occurrence earlier than Horney, in earliest infancy, as a disturbance of the attachment phase of development.

Guntrip (1980), on the other hand, used different terminology to point to and discuss some of the same things. He talked about the "Schizoid Problem", of "people who have deep-seated doubts about the reality and viability of their very (self), who are ultimately found to be suffering from varying degrees of depersonalisation, unreality, and the dread feeling of not belonging, of being fundamentally isolated and out of touch with their world". This is broadly "the Schizoid Problem", the problem of those who feel "cut off, apart, different, unable to become involved in any real relationships". Guntrip's and Horney's descriptions may be rather different, but their delineation of alienation from the self in both cases describes a paradoxical attempt on the part of the individual to survive through the sacrifice of aliveness.

In addition, Horney (1950) defined three different selves:

- (1) The actual or empirical self: which is "an all-inclusive term for everything that a person is at a given time, body and soul, healthy

and neurotic”;

- (2) The idealised self: which refers to “what we are in our irrational imagination as opposed to what we should be according to the dictates of neurotic pride”. (i.e., the impossible self);
- (3) The real self: which she describes as “the original force towards individual growth and fulfilment with which we may again achieve full identification when freed of the crippling shackles of neurosis” (i.e., the possible self).

In this frame of reference, self-alienation is alienation from the real self. Whether it is also from the actual self is less clear. These two conceptualisations do not entirely map onto each other. The lost self could be the real self, but the overlap between the idealised self and the false self or between the fragmented self and the idealised self is not self evident. Lerner (1985) specifically mentioned the fragmented self as the outcome of the process of self-alienation, which might identify the fragmented self with the actual or empirical self. Another major exponent of the concepts of the false and fragmented selves in the psychiatric literature is Laing, whose book “The Divided Self” (1965), created a sensation as a phenomenological study of what it means to be alienated from one’s self.

Karen Horney, in her book ‘Neurosis and Human Growth’ (1950), further defined real self as the “alive, unique, personal centre of our selves: the only part that can, and wants to, grow”. In the book, attention is then shifted from the real self to those forces in the individual which usurp its energies and lead to the formation of a pride system which becomes autonomous and exerts a “tyrannical and destructive power”. Horney then briefly reviews the conditions which could be subsumed under the term “alienation from the self”, from psychiatric conditions involving individuals losing their sense of identity (as in amnesia and depersonalisation), to much milder and more nebulous phenomena. She noted that alienation from self can concern the material self - body and

possessions - as well as the spiritual and emotional self. In her view, the core of alienation from self is a sense of remoteness from one's feelings, wishes, beliefs and energies: it is the loss of the feeling of being an active determining force in our own lives. The real self is further defined as the source of spontaneity of feeling, interest, energy and will, and of the motivation to grow and fulfil ourselves. It is distinguished from both the actual or empirical self (i.e., the total of what we are), on the one hand, and the idealised self on the other (the idealised self is what we are in our irrational imagination, or what we should be according to the dictates of neurotic pride). So the real self is the possible self (for neurotics), while the idealised self is impossible to attain. Horney acknowledges that it may be difficult in practice to distinguish neatly between alienation from the actual self and from the real self, but chooses to focus on the latter. She then turns to analysis of the forces responsible for alienation from self, seeing them as a consequence of the neurotic sense that "I'm driven instead of being the driver". Self-alienation is also compounded by processes which she describes as "active moves away from the real self", giving the drive for glory as an example for this phenomenon: neurotic pride leading the individual to become ashamed of what he actually is. Meanwhile, self-hate represents an active move against the real self. Thus for self-alienated individuals, their own life experience has lost its quality of personal meaning: their relationship to themselves has become impersonal, as has their relationship to their whole lives. Horney asserts that alienation from self does not show as directly and blatantly as its significance would suggest, except as states of depersonalisation, feelings of unreality, and amnesia. She claims that these conditions can only occur in people who are estranged from themselves already. The precipitating factors are usually severe injuries to pride together with an acute increase of self contempt.

2.2.2. Psychoanalytic Approaches to Addiction and Alienation

Fromm, in his book "The Sane Society" (1963), suggests that the

relationship of drug usage, especially marijuana, to rebellion is usually characterised by a feeling of apartness from the group rebelled against. This estrangement or exclusion is frequently termed, alienation. Erikson (1968) pointed to rebellion against the family as a major factor contributing to the alienation of young people and their use of drugs, an observation which has been supported in other studies (e.g., Burkett, 1977) who found that the likelihood of marijuana and alcohol use was greater among young people who had withdrawn from parental and religious relationships. Harris noted that although a cause and effect relationship had not been established between alienation and marijuana use, it did seem to be the case that, "alienation, assumed to encompass feelings of isolation, powerlessness and normlessness, was present to a greater extent in marijuana users than non users" (1971 :91).

Wurmser's (1974) work seems to point to a connection between drug abuse and self-alienation. He identified three types of drug users: experimenters who use the drug a few times to find out what it is that others are raving about but find it disappointing, so do not continue to use it; recreational users who indulge for the relaxation the drug provides rather than for intoxication; and compulsive users who become addicted to avoid the distress of depression, anger, rage and anxiety. Wurmser also identified three concomitant experiential forces that contribute to a narcissistic disturbance:

- (1) There is the family relationship pattern of parents who fail to provide positive support during developmental crises. A lack of trust develops as a result of their inconsistency.
- (2) There is a specific cause in the psychopathology of the individual which is exacerbated by an acute crisis and a massive escape from the internal distress.
- (3) There is a conflict of values as well as a pervasive sense of the limitations of human existence.

Belonging to the subculture provides a sense of camaraderie,

reflected against the inconsistencies of the family and the culture. The seductiveness of the peer group and the availability of the drugs that relieve the unbearable inner turmoil allow the drug to become the primary source of escape. Drug use, then, is identified by Wurmser (1974), as “an attempt at self-treatment for the overwhelming affects of loneliness, rage and shame”.

An important addition to the literature linking addiction and alienation is presented by Standish (2003). Standish builds on the work of Wurmser (1993), Steiner (1987) and Kohut (1994) by presenting a theory of the cycle of drug use. Rooted in psychoanalytic theory, he argues that once a person becomes addicted to a substance, drug use becomes a problem in and of itself with its own dynamics and processes – contrary to earlier psychoanalytic work, which generally treats it as a symptom of an underlying disorder. In this, he follows Leeds and Morgenstern (1996), who suggest that the presenting psychological problems of substance users may be the consequence rather than the cause of substance abuse. Standish, then, explains the cycle of drug use in addiction as a pathological narcissistic organization that interplays between the paranoid-schizoid and depressive anxieties. Following Steiner (1987), the cycle of drug use is thus seen as a defensive position against these anxieties, and this pathological organization distorts the process of development resulting in alienation from self. It is because of the latter that the cycle has to be repeated in order to maintain the defences. According to Murphy and Khantzian (1995), addiction can be considered as a form of pathological narcissism, and it is this form that the pathological organization takes in the cycle of drug use. The different steps of this cycle will now be discussed as presented by Standish (2003), using Steiner’s (1987) model and Wursmer’s (1993) formulation of the drug cycle. Attention will be drawn to the links between addiction, alienation and assertiveness.

Wursmer’s cycle, as adapted by Standish (2003), has three distinct

stages. The first stage (pre-drug use) is the build-up phase where contemplating drug use arises from intolerable tension and where phantasy solutions are created. Stage two (drug use) is the acting out phase, where acting out in the form of drug use occurs as a defence. The third stage (post-drug use) is the time when withdrawal occurs, associated with feelings of guilt and unworthiness.

Stage One

In the build-up phase, three broad events occur. Firstly, a trigger event occurs. Secondly, this increases the levels of tension with no prospect of relief except through drug use. Thirdly, drug use is seen as a solution to the tension.

Wursmer (1993) points to four categories of triggers: biological, emotional, social and behavioural. All of these can create an emotional response that the addict cannot handle. Wursmer describes this emotional response as narcissistic crisis, which leads to overwhelming affect and to affect regression, defined by Murphy and Khantzian as a “global and undifferentiated experience of emotions that can only be poorly verbalised and are therefore converted into somatic sensations”(1995 :167). As a result, there is a lowering of self-worth and self-esteem. The person is confronted with sensations rather than feelings, which are experienced as uncomfortable and overwhelming. These painful states lead to the repression of all feeling states, which set in place a craving signal – the psychosomatic response that is interpreted as the need to use (Flores and Mahon, 1993).

Stage Two

There are two broad events in the second stage: the use of drugs, followed by a reduction in affect tension. Drugs become the magically wished-for solution from the previous phase. According to Wursmer (1993), a complex compromise solution (comprising of sudden splitting of superego defences against superego functions) that results in enormous

pleasure and gratification, as the acute narcissistic conflict is momentarily resolved. However, through repeatedly resorting to drugs to achieve solutions, the addict becomes less and less able to solve his or her internal and external world problems. It is in this respect that addiction takes on a life of its own; the addict discovers that in the absence of other solutions, their distress can only be relieved by increasing the use of drugs, as reduced tension follows from the physical effects of the drug on the body. According to Wursmer (1993), the addict becomes more and more alienated and detached from his or her environment due to the effect of the drugs. He points out that the pharmacological power of the drug cannot be underestimated. It is precisely because of this power, the allowance of an attack on reality, that the addict uses drugs as a solution. At a certain point in the cycle, the active use of drugs stops, either because none are available or because the addict fears that overdose might result. This is the point where the third phase commences.

Stage Three

Steiner (1987) points out that this third stage – withdrawal – is often overlooked: the drug cycle does not only involve using drugs, but also being deprived. Withdrawal from drugs, according to Wurmser (1993), is one of the key factors in continued drug use. There are two phases in the withdrawal stage: a phase of reduced drug effect, followed by a phase of increasing levels of tension. Withdrawal is initially a physical sensation, as the biochemical and pharmacological effect wears off and comes down. This is followed by the psychological aspects and emotional loss of the substance that is experienced by the addict. He or she is caught in a vicious circle where, after the elation of the ego, the reverse occurs when the drug wears off and the ego shrinks back, with reality taking on exaggerated proportions leading to even lower self-esteem (Wursmer, 1993). According to Krystal (1993), drugs do not allow the addict to acquire the experience and skills needed to cope, hence learning fails – and it is this failure that sets up the cycle for the

repeated compulsive pattern of use. Physical withdrawal, loss of affect regulation, real time consequences, poor coping skills, shame and guilt all contribute to the levels of tension rising again. This increased tension sets the stage for a new trigger event to occur, often within a short period of time.

Understanding the cycle

This theory is a good synthesis of various different theories and models of addiction. It is compatible with many other theories in the field, even though it may not share their assumptions. For instance, the second phase could also be understood by classic conditioning theory; medical and pharmacological elements are incorporated. Alienation and self-esteem (Bandura, 1986), are integrated, rendering this theory comprehensive, complex and sophisticated. Mostly, however, it draws on psychoanalytic theory, in particular self- psychology. This perspective views addiction as a form of pathological narcissism (Kohut, 1994), where the addict suffers from a disorder of the self. This focus has the advantage that it also takes account of intra-subjective elements. In other words, not only is addiction viewed as a medical phenomenon which occurs in a specific social context, and has emotional and psychological ramifications for the addict, it also allows for an in-depth understanding of how addiction relates to the person's internal world.

2.2.3. The Link with Assertiveness

It is acknowledged that the notion of assertiveness could be regarded as controversial. As a concept, it is not politically neutral – it could imply that assertion (or specifically the lack of) is seen as weak or deficient, and it locates the person (rather than environment) as causal to the addiction. Assertiveness is also not culturally neutral, and as such could be viewed as a particular Western (especially Northern American) concept. Historically, the concept of assertiveness emerged through an empowerment discourse in the late sixties, to a certain extent as a reaction to psychoanalytic theories which were regarded as ineffective

and rather passive. To assert became almost a mantra for being free, and individual first and foremost, and for taking a stance – to be assertive is to break free from the shackles of the past, and to take control of one's life.

Nevertheless, while the concept may have these inherent difficulties, and while it may appear superficial when evaluated alongside to psychoanalytic theory, it can be a useful concept when regarded as an alternative way of coping. A lack of assertiveness has been linked to deficiencies in social skills, linking to alienation, and in turn to substitution of drugs as a way of coping (see the Standish discussion above, :64-67). Equally, in the withdrawal stage of Standish's model, he points out that drugs prevent learning; hence, the user misses the opportunity to acquire the skills by repeating the cycle, to assert him/herself in the search for healthy, positive solution. Theoretically, this is where the notions of new skill development and assertiveness fit in. To state that one should assert oneself against drugs may seem reminiscent of the Reagan-era US campaign of 'just say no' – a rather simplistic and moralistic attempt in the 'war on drugs' with little demonstrated evidence as to its effectiveness. However, some important elements can be discerned from this. Many researchers rejected the campaign on the basis that it implied blame on the substance user, and emphasised 'lack of willpower' as the cause for continuing drug use. Yet, if the blame element (which is the moral part) can be removed from the reasoning, does the free will element hold any currency?

2.2.4. Disease or Free Will?

This argument is discussed at length by Schaler (2000). He argues that the crux of the debate on addiction is the contention between, on the one hand, the disease model and, on the other hand, the free will model. Schaler argues that the disease model has outlived its usefulness in the field of addiction, just as it had done some decades earlier in dealing with homosexuality. In rejecting the disease model, he argues for a model of

free will, where it is acknowledged that humans are capable of deliberate action in the pursuit of chosen goals. Although he acknowledges that much human behaviour is not carefully thought out, he maintains that the acting person may at any moment pay more attention to thoughtless behaviour, and consciously modify it. In his argument, he distinguishes between voluntary human action and involuntary unconscious reflexes or seizures. Theoretically, Schaler anchors his argument in the concept of self-efficacy (Bandura, 1986). Self-efficacy is a person's confidence in his/her ability to achieve a specific goal in a specific situation. It refers to the ability people believe they possess to affect a specific behaviour or to accomplish a specific level of performance. Assertiveness training is one way of increasing self-efficacy (Bandura, 1986). Schaler (2000) sums up the different assumptions of the disease and free will models in two 'credos':

Credo of Disease Model:

1. Most addicts don't know they have a problem and must be forced to recognise they are addicts
2. Addicts cannot control themselves when they take drugs
3. The only solution to drug addiction is treatment
4. Addiction is an all-or-nothing disease: a person cannot be a temporary drug addict with a mild problem
5. The most important step in overcoming addiction is to acknowledge you are powerless and can't control it
6. Complete abstinence, not moderation, is the only way to control addiction
7. Physiology alone, not psychology, determines whether one person will become drug-addicted and another will not
8. The fact that addiction runs in families means it is a genetic disease
9. People who are addicted can never outgrow addiction and are always in danger of relapsing.

Credo of Free Will model:

1. The best way to overcome addiction is to rely on your own willpower
2. People can stop depending on drugs as they develop other ways of dealing with life
3. Addiction has more to do with the environments people live in than with the drugs they are addicted to
4. People often outgrow drug addiction
5. Drug addicts can learn to moderate or cut down their drug use
6. People become addicted to drugs when life is going badly for them
7. Drug addicts can and often do find their ways out of addiction without outside help
8. You have to rely on yourself to overcome an addiction
9. Drug addiction is often a way of life people rely on to cope with, or to avoid coping with, the world

These two models offer some stark differences. In practice, as is presented in chapter one, there is overlap and integration, particularly as expressed in treatment programmes. Nevertheless, it is useful to look at the contrast between these value-based assumptions. At best, Schaler argues, the 'disease' concept in the disease model is used metaphorically, as if it is physiological. Schaler offers some compelling evidence for his argument, mainly drawn from studies that researched the use of heroin in military personnel during and after the Vietnam War. He notes, for instance, that heroin users in Vietnam did not necessarily continue using once they returned to the US, and some studies (notably Robins, Helzer and Davis, 1975) challenged much of the disease model's assumptions. An even more compelling study presented in favour of the free will model is a study called Rat Park (Alexander, Hadaway and Coombs, 1980). Schaler (2000) argues that studies using laboratory animals are often used to defend the disease model. He quotes studies which show that when monkeys and rats are able to press a lever to give themselves a

dose of cocaine, they tend to do so heavily, sometimes even in preference to food, lose weight rapidly, convulse and die. The Rat Park study (Alexander *et al.* 1980) shows these findings in a different light. Alexander *et al.* (1980) argue that monkeys and rats are social and exploratory animals, and to keep them under standard laboratory conditions, in solitary confinement, unable to see another member of their species amounts to torture. They argue that pressing a lever is one of the few active things these creatures can do in such circumstances. They theorise that animals consume drugs as a way of coping with stress and environmental experiences, and not because they become enslaved to any physiological driver. To test this, they designed an experiment with rats where the animals were kept in a freer, less stressful environment. They constructed the most natural environment for rats they possibly could, and compared the rats in this environment with a control group under standard laboratory conditions. Both groups were given access to two drinkable liquids of similar taste, one with morphine added. Alexander *et al.* (1980) reported that they were astounded by the results: "No matter how much we induced, seduced or tempted them, the Rat Park rats resisted drinking the narcotic solution. The caged rats drank plenty, however, ranging up to sixteen times as much as the rat park rats in one experimental phase, and measuring ten times as much in some other phases", (Alexander *et al.*, 1980 :268-269). The Rat Park study provides strong support for the idea that environment and coping are much better predictors of opiate consumption than availability of the drug, chemical properties of the drug, or any conjectured physiological addiction characterised by tolerance or withdrawal. Schaler (2000) concludes that solitary confinement in a narrow space is as harrowing for a rat as it is for a human, and argues that if we want to understand why some people become heavy users of drugs, we should ask what it is in their lives that constitutes for them the emotional equivalent of being 'in solitary confinement'. The thesis presented here suggests that this is exactly what alienation from self represents. However, in the free will model, the 'choice' part also needs explaining. Linking back to Schaler's

argument of self-efficacy and assertiveness, I will now further investigate the concept of assertiveness.

2.3. DEFINING ASSERTIVENESS

The concept of assertiveness belongs to a constellation of related concepts, including social skills, interpersonal skills, social competence and locus of control. Bracegirdle (1990) notes the empirically established (though not necessarily causal) links between childhood social dysfunction and a range of deviant behaviours later in life. Social skills are described by Herbert (1986: in Bracegirdle, 1990) as crucial skills which, because they are not obvious or readily taught, come hard to some children. Herbert is also quoted as observing that, in childhood, social skills problems are predominantly of the “deficiency or defection kind”, while Riggio, Throckmorton and De Paola (1990) offer a categorisation of six components of social competence. They define social self-esteem as the positive self-evaluation derived from feeling good about one’s social self. Social skills, then, are defined as skills and abilities such as impression management, playing various social roles, and communicating effectively. They summarise what they see to be the core of the concept cluster as follows:

“The various conceptualisations of social skills competence all seem to agree that social competence does indeed consist of an ability, or group of abilities, that facilitate the initiation, development and maintenance of human relationships” (Riggio, Throckmorton and De Paola, 1990 :215).

A major dimension which is seen to be implicated in social competence is that of locus of control. This is a construct of reinforcement expectancy that emerged from Rotter’s (1972) theory of social learning. The construct places individuals on an internal-external continuum of reinforcement expectancy according to their perceptions of cause and effect relationships in daily life. Internally controlled individuals expect reinforcement as a consequence of “their own actions

and choices, they feel a degree of personal power to influence or control their own destiny” (Parks, Becker, Chamberlain and Crandell, 1975 :34). Externally controlled individuals, on the other hand, expect reinforcements to occur randomly, as a result of events or conditions over which they have little or no control. Externally controlled people believe that the actions of others or chance determine outcomes more than their own behaviour. The link with concepts of assertiveness is obvious: people are more likely to be assertive if they believe outcomes are related to their behaviour, than if they believe they are random. Nevertheless, the study of these issues, and of the literature reporting findings connected with them, is difficult to interpret, given the lack of agreement on the use of terms:

“There is a fundamental problem inherent in the assessment of social skills, because of the absence of a clear definition of social competence” (Bracegirdle, 1990 :97).

He suggests that the concept of assertiveness is best viewed as a subset of social competence, connected with certain sorts of social or interpersonal or interactive skills, and probably as an external manifestation of internal locus of control.

Wolpe and Wolpe (1988) defined assertiveness as “all socially acceptable expression of right feelings”. A few years later, their view had shifted, and they defined assertive behaviour as “the proper expression of any emotion other than anxiety towards another person”, while in 1970 Albert and Emmons defined assertiveness as “behaviour which enables a person to act in his own best interest, stand up for himself without undue anxiety, to express his rights without destroying the rights of others”. Minkin, Brankmann, Minkin, Timbers, Timbers, Fixsen, Phillips and Wolf (1976) complained that “some behaviours are more complex and difficult [to specify], especially socially important behaviours that include numerous component parts these behaviours are often

described in vague generalities, which do not provide a basis for measurement”.

Assertiveness is usually contrasted with lack of assertiveness, or unassertiveness, although both these concepts may be “triangulated” with the concept of aggression. This is usually seen as the “bad” aspect of assertiveness, which involves hostility, anger and destructiveness, whereas assertion is assumed to involve rational and reasonable expression of rights and needs. “As traditionally defined, assertiveness is the effective communication of personal thoughts and feelings in interpersonal encounters in a fashion that respects and regards the thoughts and feelings of others” (Elliott and Gramling, 1990). “Positive assertion” has been defined as the “expression of positive feelings such as worth, affection, joy and appreciation”, as opposed to “negative assertion”, which is described as “the ability to show legitimate opposition and make socially appropriate demands”. For instance, the assumption, widely made in the literature, is that the deficit in assertiveness which needs to be remedied has to do with negative assertiveness: “Assertiveness training focuses on both verbal and non-verbal (paralinguistic) assertive behaviours. Verbal assertive skills involve learning what to say (no-statements, requests, refusals) whereas non-verbal assertive skills include eye contact, loudness of voice, facial expressions, distance and body expression” (Botvin, 1984). Non-assertive behaviour, as Dawley (1976) underlined, is related to learning experiences:

“Non-assertive behaviour, like most behaviour, can be explained to a large extent in terms of learning. Non-assertive people either have not learned to assert themselves or have been conditioned not to assert themselves by being taught that assertive behaviour is undesirable. Efforts at self-assertion thus become sources of fear, anxiety, and guilt” (1976 :19).

2.3.1. Assertiveness and Addiction Research

Botvin (1986) claims that “basic interpersonal skills are necessary for confident, responsive and mutually beneficial relationships and are perhaps among the most important skills that an individual must learn. Inadequate social skills may cause problems in interpersonal relationships or may interfere with optimal functioning in school, work or recreational situations”. When thinking about and evaluating the situation of the addict, it becomes clear that training in assertiveness skills could indeed be effective in alleviating the person’s sense of alienation, hence reducing the addiction, by helping her/him to build a ‘coping strategy’. Several other investigators also suggest that drug addicts are deficient in social skills. Kraft (1968) posits anxiety related to social situations as a major determinant of drug abuse. He suggests that reduction of social anxiety will lead to cessation of drug use. More traditionally oriented investigators appear to be in general agreement that drug addicts are a population characterised by low self-esteem, with numerous deficiencies in those skills requisite for effective social performance. Cheek *et al.* (1973) refer to the possibility of “under-assertive” addicts resulting from the “reinforced hesitation about expressing any aggression”. Dawley (1976) suggested that this is an appropriate description of drug addicts. Brill (1963) described addicts as “introverted, sensitive, quiet, passive, and submissive individuals, who need drugs as an escape from loneliness, isolation, and boredom in their personal lives” (1963 :18). However, Van Hasselt *et al.* (1978) argued that it cannot be maintained that drug addicts are unskilful in terms of social skills: they may be very skilful in ways which are appropriate within the drug culture (e.g. ‘conning behaviours’).

One of the interesting findings is that relapse following treatment is often related to the deficient behaviour repertoire of alcoholics. This also appears to be true for drug addicts (Cheek *et al.*, 1973; Brill, 1963). An exception is outlined in a study by Callner and Ross (1978). They conducted one of the only studies specifically designed to examine effectiveness of assertiveness training with drug addicts. Though the

results of the study were positive, no follow-up data were reported. The size of the sample was also small (eight students in all: four in treatment group; four in control group) so the results need to be treated with caution. Callner and Ross (1978) found no significant differences on questionnaire subscales, but they did find significant differences on verbal results. They took these results to support the proposition that the measurement of assertion by specific situational problem areas may be more effective than measures of general assertive ability. Social skills training procedures with drug addicts have been amongst the many factors complicating interpretation of the results.

2.4. POSITION OF THE THESIS

1. Many research studies as well as government policies illustrate that drug users are alienated from society. Some also acknowledge alienation from self. Drug user populations in the West (especially heroin users) are predominantly from deprived backgrounds, problematic upbringings, socially and economically disadvantaged. In Saudi Arabia, while less is known about the background, there is still a clear indication that drug users are alienated from the predominant mores of society. Both societies acknowledge that the reasons for this alienation are complex and not well understood (see, for instance, the 2001 Drugscope Report in the UK, and the 2001 Iqbal article in Saudi Arabia). The argument I propose here is that one aspect of this social alienation arises through the interaction with self-alienation.
2. Psychoanalysis offers an insight into the workings of being alienated from self.
3. It also offers an insight into the link between being alienated from self and addiction. In particular, Standish's model shows that, apart from other underlying and contextual causes, the cycle of addiction both perpetuates and reinforces an alienation from self. This cycle illustrates, particularly in the final stage of the model, why it is difficult to get the addict out of the cycle, as the

addiction prevents learning taking place.

4. Since many approaches emphasise the learning of social skills (including assertiveness) as a core part of drug rehabilitation, it seems important to investigate the level of assertiveness present in substance users. The argument put forward by Schaler (2000) is also appropriate here, as it both offers a critique of the dominant disease model and posits a free will hypothesis as an alternative explanation. If drug users do indeed have a choice, then measuring the extent to which they have the ability to assert themselves against drug use and 'say no' becomes an important area to investigate.

CHAPTER THREE: FROM THEORY TO EVIDENCE: OPERATIONALISATION AND METHOD

3.1. INTRODUCTION

Since the basic aim of this study is the investigation of an individual's degree of sense of self as related to the level of addiction, it was thought necessary to assess three different areas. Firstly, a thorough personal history needed to be collated for each participant, enabling the subsequent analysis of individual differences according to different life experiences. As an exploratory first step, this might reveal patterns previously unnoticed. Secondly, a measure of self-alienation needed to be employed, investigating the degree of alienation experienced by the different sub-populations. Thirdly, as social skills can be seen to contribute to better integration into society, thus facilitating self-integration, an assertion measure needed to be employed to test this hypothesis. The sections entitled 'Position of the Thesis' in both preceding chapters offer a clear rationale for linking the concepts of addiction, alienation and assertiveness.

In this chapter, the recruitment strategy, the procedure, and descriptive of the different samples are presented. Further, the materials used are described, and their psychometric properties are evaluated through the use of Cronbach's alpha to ascertain reliability, and through factor analysis to ascertain validity.

At the time of designing the study in 1996, few systematic investigations in to drug use and addiction in a Middle Eastern context had taken place. Anecdotally, however, it was clear to me that while there was no official recognition of addiction as such, it was common knowledge that people were using a variety of drugs and indeed

experiencing problems through their use. A ramification of the ‘official denial’ of a drug problem was that substance users did not have access to appropriate treatments, and the usual sources of support such as families and friends were not informed as how to deal with someone who was taking drugs. Drug use was regarded as ‘foreign’, incomprehensible and completely taboo.

Nevertheless, the medical profession and the police did encounter progressively more cases, and a series of treatment centres was established. The main purpose of these centres in their initial conception was to offer a detoxification programme, combined with religious therapy, to ensure addiction would be ‘cured’ – the rationale being that taking drugs was a sign of being alienated from God, and only a return to Him could effectively cure the addict from his (invariably, the visible drug user was male) maladaptive ways. My aim then was to seek some further understanding of the addiction phenomenon in Saudi Arabia. I was also intrigued by the notion that addiction was linked to alienation (in this case, from God), and wanted to explore this further.

Since most measures were constructed in the West, and since I wanted to be able to compare Saudi findings with other studies, I decided to use a comparison group from the UK. The rationale was to examine how addiction, alienation and assertiveness could be integrated as a coherent package.

3.2. PARTICIPANTS

As this study contains a cross-cultural objective, participants were recruited in both Saudi Arabia and the UK. The samples consist of heroin users, compared with control groups. Specific information and demographics will be provided under each sub-section.

As with all research conducted with (or partially including) clinical samples, the ethical guidelines as set out by the British Psychological

Society were rigorously adhered to, both in the UK and in Saudi Arabia. Ethical approval forms can be found in the appendix. Details of this are discussed for each part of the study in detail.

3.2.1. Recruitment of Participants

In Saudi Arabia, I recruited participants from the Al Amal, the only hospital in Riyadh at the time that provided medical treatment for drug users. In the first instance, I contacted the Hospital Management Board, who gave permission for the study to be undertaken.

Given that I am female, personal contact with the potential participant group was not granted by the Board. Instead, I was allowed to liaise with a male social worker, and I briefed him on the context and content of the study, as well as the ethical guidelines for conducting research of this nature and requested him to explain to the participants the following elements:

- The aim of the study: to understand more about drug use in Saudi Arabia, about drug users and their attitudes.
- Anonymity: no names would appear on the questionnaire, and no record would be kept of who returned the questionnaire and who did not. Questionnaires would be returned in a locked box located in a central location, and only the researcher would have access to them. Hospital staff would not see the completed questionnaires at any point.
- Confidentiality: the objective of the study was to look at trends rather than individuals. Therefore, no specific cases would be reported, but just general trends. Participants were also informed that any questionnaires received would be kept safe under lock and key, and would be safely destroyed once the undertaking of the study was completed.
- Participants were informed that they were free to chose whether they wanted to participate or not. They could return a completed

questionnaire, an empty questionnaire, or not return a questionnaire at all. They were also informed that while we encouraged them to complete as many questions as possible, they could skip questions if they did not feel comfortable about them. It was also stressed that the study was independent of the hospital. They were informed that when questionnaires were received, they would be entered in a database and the results analysed for scientific purposes. It was made clear that if they did submit data to the researchers this would be taken to mean that they consented to have this data used for the purposes of the study.

The consent form, (following the British Psychological Society guidelines), the Assertion Questionnaire, Alienation from Self Questionnaire and the Personal History Form were distributed, and participants were asked to complete these documents. The cover of the questionnaire reiterated the points that were raised in the form. In total, 116 questionnaires were distributed, 83 of these were returned completed, and 3 were blank and not included in the study. This was an excellent response rate. I ensured that the box in which these questionnaires were returned had not been tampered with, and entered the data into an SPSS data file.

One unfortunate part of the procedure was that I was not allowed to debrief and give the participants access to the generic results of the study. While I acknowledge that this would be good practice, the Hospital Management Board did not allow this, nor were they interested in receiving feedback on the results of the study. However, it was agreed that should any debriefing be required (in terms of participants' having an adverse response as a result of participating in the study) it would be managed within the normal relationship/intervention with the participants. As such, the researcher did not get directly involved with the debrief.

In the UK, both in-patients and out-patients were recruited as part of the study. My first supervisor facilitated access to five different centres, and two of these granted permission for the study to be conducted. For the in-patient group, the personal history form, questionnaires and the consent form, (following the British Psychological Society guidelines) were given to the participants. The consent form informed the participants that all information would be treated in confidence; that the patient had the right to withdraw at any time without any obligation; and that non-participation in, or withdrawal from the study would not influence treatment provision. A locked box was provided in a central space for the return of the questionnaire. The questionnaires were distributed over a period of two weeks, as the centre had a relatively high transient population. 40 questionnaires were made available, of which 21 were returned and could be used for analysis, giving a response rate of just over half. Given that users attending the centre did not stay for longer than approximately one month, it was not possible to provide generic feedback.

For the out-patient group, it was agreed with the management of the centre that I would wait at the centre and approach each user who entered and ask them whether they would be prepared to participate in the study. This was a difficult way of recruiting. Very few attendees consented to participation, as research was clearly considered to be a low priority. Many users attending the centre were also intoxicated, hence it was not possible to conduct the research with them. Over 100 potential users were approached over a period of three weeks, with 12 consenting to participate in the study. Again, participants were informed regarding the aims of the study, the protection of their anonymity and confidentiality, and what subsequently would happen with the data. Those that continued with the questionnaire were taken as having given informed consent to participate in the study.

To ensure that the hypotheses could be meaningfully tested, it was

important to recruit two control samples. Both in Saudi Arabia and in the UK, the control groups consisted of university students. Permission was sought from the course director in two institutions (one in Riyadh, one in London), and I made a brief presentation to potential participants about the aims of the study (*in Saudi Arabia, this happened through the social worker as all students were male*). Consent form, personal history form and questionnaires were distributed, and a box was placed at the exit of the room. Both in Saudi Arabia and in the UK, 50 questionnaires were made available. 30 were returned completed for Saudi control sample, and 26 for the UK control sample.

Further descriptive information on these groups will be presented below.

3.2.2. The Five Groups

3.2.2.1. Group One: Saudi Drug Users

Participants were 83 male drug users who were in-patients and received treatment and medical supervision in the Al Amal. Patients may refer themselves, or be referred by relatives, GPs, hospitals or prisons. Diagnosis of patients was based on psychiatric criteria according to DSMIII-R. The participants' age range was between 18 and 40, with a mean of 27.24. 8.4% of participants belonged to Band A (earning £0-£15,000), 88% to Band B (£15,000- £25,000), while 2.4% fell under Band C (£25,000+).

19.3% were educated to the equivalent of GCSE level, 79.5% had A-levels, and 1.2% had a degree. 9.6% were students, while the vast majority (90.4%) was unemployed. In terms of marital status, 51.8% were single, 43.3% married, while 4.8% reported 'other', which assumes engagement or co-habitation. Drug use for this sample is presented in Table One next page.

Table One: Drug Use (Ever used) For Group One

<i>DRUG</i>	<i>PERCENTAGE OF USERS</i>
<i>ALCOHOL</i>	70.4%
<i>TOBACCO</i>	50.6%
<i>TRANQUILLISERS</i>	24.1%
<i>AMPHETAMINES</i>	7.2%
<i>LSD</i>	2.4%
<i>CANNABIS RESIN</i>	55.4%
<i>COCAINE</i>	12%
<i>HEROIN</i>	97.6%
<i>ECSTASY</i>	1.2%

95.4% wanted a fix at the time of being asked the question, while 4.6% did not.

The age range at which participants started using drugs is from 16 to 26, with 2.4% starting at 16, 9.6% at 17, 14.5% at 18, 27.7% at 19, 20.5% at 20, 10.8% at 21, 3.6% at 22, 3.6% at 23, 2.4% at 24, 3.6% at 25 and 1.2% at 26.

96.4% started using drugs through friends, 2.4% through strangers and 1.2% reported other sources.

Participants were also asked about parental and family drug use. 6.3% of fathers used drugs heavily, 7.3% were light users, and 86.4% did not use drugs at all. 2.4% of mothers were heavy users, while 97.6% did not use drugs. 8.5% of siblings were heavy users, 2.4% light and 89% did not use drugs. 'Light' and 'heavy' were subjectively defined.

Participants were asked about a history of sexual abuse. 96.4% reported that they were not abused. 3.6% were sexually abused by their

mother. Age of abuse was asked, but not reported. 32.7% were not beaten as children. However, 57.8% were beaten by their father, 1.7% were beaten by their mother, 4.8% by both parents, and 2.6% by others.

Parental treatment was further investigated. 49.4% of participants considered themselves to be strictly treated by their father, 20.5% moderately strictly, 6% not strictly, 14.5% smothering and 9.6% loving. 1.2% reported their mother 'could not care less about them'.

Religious beliefs were also reported. Of the sample, 100% reported believing in God, 41% reported being active mosque members, 59% were not. 14.5% considered themselves very religious, 48.2% moderately religious and 37.3% not religious.

Parental religious beliefs were also reported. 73.5% of fathers were very religious, 24.1% moderately religious, while 2.4% were not religious at all. 79.3% of mothers were reported to be very religious, 15.8% as moderately religious and 4.9% not religious. 10.8% of participants described themselves as very happy, 24.1% as moderately happy, 33.7% as unhappy, while 31.3% proclaimed not to know their degree of happiness.

3.2.2.2. Group Two: UK Drug Users – In-patients

Participants in Group Two consisted of 12 males and 9 females (total n=21), with a mean age of 31.86. All were notified English drug users receiving treatment on either maintenance or reducing prescriptions from Drug Dependency Units or from GP shared care programmes. The range of problems presented to psychologists and therapists by this client group encompassed situational social problems, clinical states, drugs, and often a history of being rebuffed or repulsed by a 'nine-to-five' world (as defined by the case workers).

Of the total sample, 90% belonged to economic status Band A, 9.5%

to Band B. Education levels were established at 81% for GCSE, 19% at A-level. 100% were unemployed; 76.2% were single, none married, and 23.88% either engaged or co-habiting. Drug use for this sample is presented in Table Two below.

Table Two: Drug Use (Ever used) for Group Two

<i>DRUG</i>	<i>PERCENTAGE OF USERS</i>
<i>ALCOHOL</i>	95.2%
<i>TOBACCO</i>	95.2%
<i>TRANQUILLISERS</i>	76.2%
<i>AMPHETAMINES</i>	61.9%
<i>LSD</i>	72.2%
<i>CANNABIS RESIN</i>	90.5%
<i>COCAINE</i>	90.5%
<i>HEROIN</i>	95.2%
<i>ECSTASY</i>	38.1%

100% wanted a fix at the time of being asked the question.

The age range at which participants started using drugs is from 13 to 21, with 4.8% starting at 13, 4.8% at 15, 4.8% at 16, 19% at 17, 19% at 18, 23.8% at 19, 19% at 20, and 4.8% at 21.

85.7% started using drugs through friends, 4.8% through strangers and 9.5% reported other sources.

Participants were also asked about parental and family drug use. 33.3% of fathers used drugs heavily, 33.3% were light users, and 33.3% did not use drugs at all. 4.8% of mothers were heavy users, 42.8% light users while 52.4% did not use drugs. 38.1% of siblings were heavy users, 23.8% light and 38.1% did not use drugs.

Participants were asked about a history of sexual abuse. 85.9% reported that they were not abused. 4.7% were sexually abused by their father, 4.7% by someone in their family, and 4.7% by a stranger. Age of abuse was not reported by 90.5% of participants; of those who did, 4.8% were abused at five years of age, 4.8% at eleven. 33% were not beaten as children. However 57.1% were beaten by their father, 9.5% were beaten by their mother.

Parental treatment was further investigated. 52.4% of participants considered themselves to be strictly treated by their father, 42.8% moderately strictly, 4.8% not strictly. Mothers' treatment was regarded as moderately strict by 14.3%, not strict by 4.8%, 14.3% regarded it as smothering, while 57.1% described it as loving. 9.5% reported their mother 'could not care less about them'.

Religious beliefs were also reported, 57.1% of the sample reported believing in God. 42.9% did not. 9.5% reported being active church members. 90.5% were not. 9.5% considered themselves moderately religious and 90.5% not religious.

Parental religious beliefs were also reported. 50% of fathers were moderately religious, while 50% were not religious at all. 5% of mothers were reported to be very religious, 65% as moderately religious and 30% as not religious. 4.8% of participants described themselves as very happy, 38.1% as moderately happy, 57.1% as unhappy.

3.2.2.3. Group Three: UK Drug Users – Out-patients

Group Three consisted of 12 English out-patients, 10 male and 2 female, with a mean age of 30.67, on reducing prescriptions from Drug Dependency Units or from GP shared care programmes.

Economic status was Band A for 83.3%; the rest of the sample did not volunteer this information. All were unemployed (100%), 58.3%

were single, 8.3% were married; others equaled 16.6%. Drug use for this sample is presented in Table Three below.

Table Three: Drug Use (Ever used) for Group Three

<i>DRUG</i>	<i>PERCENTAGE OF USERS</i>
<i>ALCOHOL</i>	91.7%
<i>TOBACCO</i>	91.7%
<i>TRANQUILLISERS</i>	83.3%
<i>AMPHETAMINES</i>	100%
<i>LSD</i>	91.7%
<i>CANNABIS RESIN</i>	91.7%
<i>COCAINE</i>	91.7%
<i>HEROIN</i>	83.3%
<i>ECSTASY</i>	50%

75% wanted a fix at the time of being asked the question, while 25% did not.

The age range at which participants started using drugs is from 15 to 21, with 8.3% starting at 15, 16.7% at 16, 33.3% at 17, 16.7% at 18, 16.7% at 20, and 8.3% at 21.

83.3% started using drugs through friends, 8.3% through husband or wife and 8.3% reported other sources.

Participants were also asked about parental and family drug use. 41.7% of fathers used drugs heavily, 33.3% were light users, and 25% did not use at all. 21% of mothers were heavy users, 21% were light users, while 58% did not use drugs. 8.3% of siblings were heavy users, 2.4% light and 89% did not use drugs.

Participants were asked about a history of sexual abuse. 91.7% reported that they were not abused. 8.3% were sexually abused by a stranger. Age of abuse was asked, but not reported. 58.3% were not beaten as children. However, 16.7% were beaten by their father, 16.7% were beaten by their mother, and 8.3% by others.

Parental treatment was further investigated. 33.3% of participants considered themselves to be strictly treated by their father, 41.7% moderately strictly, 25% not strictly. Mothers' treatment was regarded as strict by 50%, moderately strict by 33.3% not strict by 16.7%.

Religious beliefs were also reported. Of the sample, 58.3% reported believing in God, 41.7% did not. 16.7% reported being active church members, 83.3% were not. 8.3% considered themselves very religious, 25% moderately religious and 66.7% not religious.

Parental religious beliefs were also reported. 25% of fathers were moderately religious, while 75% were not religious at all. 58.3% of mothers were reported to be moderately religious and 41.7% as not religious. 66.6% of participants described themselves as moderately happy, 33.3% as unhappy.

3.2.2.4. Group Four: Saudi Control Group

Group Four was a control group, with 30 participants living in Saudi, non-drug users, and attending a full time university programme. All were male, with a mean age of 22.10. In terms of economic status, 13.3% fell under Band A, 40% under Band B, and 43.3% under Band C. No marital status information was collected. Drug use for this sample is presented in Table Four next page.

Table Four: Drug Use (Ever used) for Group Four

<i>DRUG</i>	<i>PERCENTAGE OF USERS</i>
<i>ALCOHOL</i>	0%
<i>TOBACCO</i>	6.7%
<i>TRANQUILLISERS</i>	3.3%
<i>AMPHETAMINES</i>	0%
<i>LSD</i>	0%
<i>CANNABIS RESIN</i>	0%
<i>COCAINE</i>	0%
<i>HEROIN</i>	0%
<i>ECSTASY</i>	0%

Participants were also asked about parental and family drug use. 100% of fathers, mothers or siblings did not use drugs at all.

Participants were asked about a history of sexual abuse; none was reported. 13.3% were not beaten as children. However, 56.7% were beaten by their father, 6.7% were beaten by their mother, 6.7% by others, 13.3% by both parents, and 3.3% by both parents and others.

Parental treatment was further investigated. 6.7% of participants considered themselves to be moderately strictly treated by their father, 50% not strictly, 20% smothering and 23.3% loving. Mothers' treatment was regarded as not strict by 30%, 10% regarded it as smothering, while 60% described it as loving.

Religious beliefs were also reported. Of the sample, 100% reported believing in God, 26.7% reported being active mosque members, 73.3% were not. 6.7% considered themselves very religious, 56.7% moderately religious and 36.3% not religious.

Parental religious beliefs were also reported. 6.7% of fathers were very religious, 83.3% moderately religious, while 10% were not religious at all. 9.2% of mothers were reported to be very religious, 81.6% as moderately religious and 9.2% as not religious. 12.3% of participants described themselves as very happy, 63% as moderately happy, 24.7% as unhappy.

3.2.2.5. Group Five: UK Control Group

Group Five is the UK control group, consisting of 26 students at Roehampton Institute London, an Institute of Higher Education, part of the University of Surrey. It was thought that as the Saudi control group was an undergraduate sample, it was necessary to use a control sample comprising English undergraduates. 4 males and 19 females (3 participants did not state their gender), with a mean age of 29.27, made up this group. 16.7% fell under economic status Band A, 50% under Band B, and 12.5% under Band C. Marital status data was not collected. Drug use for this sample is presented in Table Five below.

Table Five: Drug Use (Ever used) for Group Five

<i>DRUG</i>	<i>PERCENTAGE OF USERS</i>
<i>ALCOHOL</i>	52.6%
<i>TOBACCO</i>	47.4%
<i>TRANQUILLISERS</i>	0%
<i>AMPHETAMINES</i>	10.5%
<i>LSD</i>	5.6%
<i>CANNABIS RESIN</i>	31.6%
<i>COCAINE</i>	0%
<i>HEROIN</i>	0%
<i>ECSTASY</i>	5.3%

15.8% wanted a fix at the time of being asked the question, while 84.2% did not.

The age range at which participants started using drugs is from 9 to 18, with 22.2% starting at 9, 11.1% at 13, 11.1% at 14, 11.1% at 15, 11.1% at 16, 11.1% at 17 and 22.2% at 18. 100% started using drugs through friends.

Participants were also asked about parental and family drug use. 5.3% of fathers used drugs heavily, and 94.7% did not use drugs at all. 10.5% of mothers were heavy users, 5.3% light users, while 84.2% did not use drugs. 5.3% of siblings were light users and 94.7% did not use drugs.

Participants were asked about a history of sexual abuse. 94.7% reported that they were not abused. 5.3% were sexually abused by a member of their family. Age of abuse was reported as nine for 66.7% of those abused and eleven for 33.3%. 84.2% were not beaten as children. However, 10.5% said that they were beaten by their father, 5.3% by their mother.

Parental treatment was further investigated. 26.3% of participants considered themselves to be moderately strictly treated by their father, 36.8% not strictly, 15.8% smothering and 10.5% loving. 10.5% reported being neglected. Mothers' treatment was regarded as strict by 5.3%, moderately strict by 15.8%, not strict by 10.5%. 31.6% regarded it as smothering, while 36.8% described it as loving.

Religious beliefs were also reported. Of the sample, 61.1% reported believing in God, 38.9% did not. 15.8% reported being active church members, 84.2% were not. 5.3% considered themselves very religious, 26.3% moderately religious and 68.4% not religious.

Parental religious beliefs were also reported. 5.3% of fathers were very religious, 31.5% moderately religious, while 63.2% were not religious at all. 5.3% of mothers were reported to be very religious,

26.3% as moderately religious and 68.4% as not religious. 15.8% of participants described themselves as very happy, 73.7% moderately happy and 10.5% unhappy.

3.4. MATERIALS

This part of the thesis will present an overview of the measures used for the alienation and assertiveness constructs. Although other techniques such as Figure Placement (Ziller, 1971)² could be employed to measure alienation, reliability and validity issues, combined with issues around sampling difficulties, indicated that questionnaires were the best available tool to measure both alienation and assertiveness. The alienation questionnaire used was chosen because the items were developed to assess self, peer and social alienation. All three aspects were considered important because of the cultural comparisons that were being researched. Moreover, the questionnaire chosen was the only one that had been used with psychotherapy patients who most closely resembled to the population being studied in this research.

3.4.1. Alienation Questionnaire

This questionnaire measures three kinds of alienation; Alienation from Society, Peers, and Self, as identified in “A Study of Patients and Therapist in Traditional and Free Out-patient Mental Health Clinics”, by Merwin (1974). Several other ways of measuring alienation were considered. Projective measures and conceptual distance indices were reviewed, but deemed impractical. The projective measures involved qualitative analysis, which was not suitable for the purposes of this study, as it would not allow for quantitative comparison. The conceptual distance indices were considered to be too complex to use with a drug using population. Further, Merwin’s conceptualisation and operationalisation of alienation is unique as it deals directly with various

² Figure Placement is based on Kueth’s (1969) social schema method and was originally employed as a projective measure of social distance strategies. Modifications of this technique have been used to measure alienation constructs. Participants are asked to place a ‘self circle’ on a page containing a triangle of ‘other circles’. Placement inside the boundaries of the triangle was interpreted as a measure of social interest in others.

forms of alienation. Other measures take a number of theorised sub-concepts such as powerlessness, hopelessness and isolation (for instance, Neal and Seeman, 1964), but do not directly measure alienation as such. Other data often used to ascertain the level of alienation in a society are those for suicide rates, arrests for vandalism, etcetera. Again, these were not deemed appropriate for this study, as these kinds of data operate at a different level of analysis.

Merwin devised a scale to examine each of these three aspects of Alienation:

- (1) Alienation from society-scale;
- (2) Alienation from peers-scale;
- (3) Alienation from self-scale.

3.4.1.1. Alienation From Society

Merwin's (1974) scale items for this aspect were drawn from Srole's (1959) scale, and from a scale developed by McClosky and Schaar (1965):

- (1) Community leaders are indifferent to his needs;
- (2) Little can be accomplished in a society whose social order is essentially unpredictable;
- (3) Social goals are receding from him rather than being reached;
- (4) No one can be counted on for support;
- (5) Life is meaningless and futile.

McClosky and Schaar claim that "the items express the feelings that people today lack firm convictions and standards, that it is difficult to tell right from wrong in our complex and disorderly world, that the traditional values which gave meaning to the individual and order to the society have lost their force, and that the social ties which once bound men together have dissolved" (1965 :14).

Operationalising these postulations, Srole's (1959) items are:

- (1) In spite of what some people say, things are worse for the average man;
- (2) It's hardly fair to bring children into the world with the way things look for the future;
- (3) Nowadays a person has to live pretty much for today and let tomorrow take care of itself;
- (4) There is little use in writing to public officials because often they aren't really interested in the problems of the average man;
- (5) These days a person doesn't really know who he can count on.

McClosky and Schaar's (1965) items are:

- (1) With everything in such a state of disorder, it's hard for a person to know where he stands from one day to the next;
- (2) Everything changes so quickly these days that I often have trouble deciding which are the right rules to follow;
- (3) I often feel that many things our parents stood for are just going to ruin before our eyes;
- (4) I often feel awkward and out of place;
- (5) People were better off in the old days when everyone knew how he was expected to act;
- (6) It seems to me that other people find it easier to decide what is right than I do.

3.4.1.2. Alienation From Peers

As Merwin conceived it, peer alienation occupies a conceptual middle position between social and self-alienation: "One's peers logically stand in closer relation to one's self than does society at large" (1974 :34). Merwin utilised Turner's (1968, quoted in Merwin, 1974) subscale on peer alienation which, in Merwin's view, appears to address the general perception of detachment from one's "inner circle" of

acquaintances. Turner's items are:

- (1) I have nothing in common with most people my age;
- (2) My way of doing things is not understood by others my age;
- (3) It is safer to trust no-one, even so called friends;
- (4) Most of my friends waste time talking about things that don't mean anything;
- (5) In the group that I spend most of my time with, most of the men/women don't understand me.

3.4.1.3. Alienation From Self

Merwin (1974) states that less use has been made of this construct in empirical research than of the others. On the whole, it is mostly used by psychoanalytic writers, in particular in the work of Karen Horney (1945). Horney claims that "through the eclipse of large areas of the self by repression and inhibition as well as idealisation and externalisation, the individual loses sight of himself". (1945 :132). Merwin also refers to Laing's (1965) indictment of Western man as severely self-alienated: "Our capacity to think, except in the service of what we are dangerously deluded in supposing is our self interest, is pitifully limited: our capacity to see, hear, touch, and smell is so shrouded in veils of mystification that an intensive discipline of unlearning is necessary for anyone before one can begin to experience the world afresh, with innocence, truth and love" (1974 :65).

A number of writers have speculated about a trend in Western life towards greater self-alienation: Rosenthal (1983) described Western man as increasingly "other directed", no longer directed by his inner states, but operating in conformity with the definitions and approval of others. Schachtel (1961) pointed to the role of information technology and "experts" as usurping more and more human experience, and reducing it to "data" which can be processed by computers.

Taviss (1969) attempted to document this hypothetical trend from social to self-alienation during the period from 1900 to 1950. Using a thematic analysis of popular fiction, she found a significant trend towards self-alienated themes during this period. Merwin (1974) found that the scale which he had developed to measure self also measured several indices of more severe psychopathology. In that study, self-alienation and social alienation were found to be characterised by different MMPI scale configurations.

Merwin's original self-alienation scale (1970) was extended to include items intended to assess five aspects of self-alienation:

- (1) experience of one's activity as alien;
- (2) experience of one's self as alien;
- (3) experience of one's past as alien or unknown;
- (4) experience of one's dreams and fantasy as irrelevant or meaningless;
- (5) experiencing uncertainty as to one's own feelings.

The items are:

- (1) I feel I know myself pretty well;
- (2) I often do things without knowing why;
- (3) I seldom have a feeling of emptiness;
- (4) I remember most of what happened in my early childhood;
- (5) I feel I am too much what others want me to be;
- (6) My dreams seldom make much sense to me;
- (7) Sometimes I am bothered because I don't know how I got to be the kind of person I am;
- (8) Very often I feel like a stranger to myself;
- (9) My dreams seem irrelevant to me;
- (10) Often it's hard for me to make up my mind because I don't know how I really feel about something.
- (11) Often when I have an experience I feel that it isn't really

happening to me.

3.4.1.4. Factor Analysis

As most of the scales are rather dated, but because they still, to date, form the most sensitive instrument to measure alienation, it was deemed necessary to factor analyse both questionnaire data sets for all samples to ensure validity of the questionnaire. Principal Components Analysis extracted two factors; a three and four factor solution were also considered, but it seemed that the two factor extraction was the most satisfactory solution, based on the principle of parsimony yet still accounting for a respectable percentage of the variance (33.7%). Table Six on the next page shows the Factor Loadings, Commonalities and Percentages of Variance accounted for.

Table Six: Factor Loadings. Commonalities and Percentages of Variance

<i>ITEMS</i>	<i>FACTOR ONE</i>	<i>FACTOR TWO</i>
<i>1- kind of person</i>		
<i>2-where to stand</i>	.21	.48
<i>3- nothing in common</i>		.52
<i>4-what others want</i>	.48	
<i>5-out of place</i>	.70	
<i>6- my dreams</i>	.24	.27
<i>7- public officials</i>	-.22	.62
<i>8- my way of doing things</i>	.21	.46
<i>9- stranger to myself</i>	.78	
<i>10- how to act</i>		.64
<i>11- early childhood</i>		-.27
<i>12- live for today</i>	.50	
<i>13- safer to trust no-one</i>		.48
<i>14- things are getting worse</i>		.44
<i>15- don't know myself</i>		.22
<i>16- trouble deciding</i>	.28	.37
<i>17- without knowing why</i>	.74	
<i>18- having children</i>	.63	
<i>19- emptiness</i>	.43	
<i>20- waste time talking</i>		.70
<i>21- parents stood for</i>		.60
<i>22- make up my mind</i>	.60	
<i>23- whom to count on</i>		
<i>24- experiences</i>	.20	.53
<i>25- group doesn't understand</i>	.28	.41
<i>26- decisions</i>	.74	
<i>27- daydreams</i>	.50	
<i>VARIANCE</i>	21.2%	10%

Factor One has an Eigen Value of 6.72, with 21.2% of the variance accounted for; this factor was interpreted as the self-alienation factor. Factor Two has an Eigen Value of 2.40, with 10% of the variance accounted for. This factor was interpreted as social alienation.

3.4.1.5. Reliability Analysis

The total ASQ scale, comprising 21 items (items 1, 6, 11, 5 and 23 were removed, as they had loadings of less than .4) as measured on a sample of 157 participants (n=157), delivered a Cronbach's alpha of .8748. Reliability for Factor One, comprising 9 items, delivered an alpha of .6873. Cronbach's alpha for Factor Two, comprising 12 items, was observed at .8380. Reliability is therefore established as highly satisfactory.

3.5. ASSERTION QUESTIONNAIRE

Social skills elude measurement; even if participants demonstrate that they have the necessary 'knowledge' about certain skills, this does not necessarily translate into those skills actually being used. In other words, attitudes do not necessarily translate into behaviours. In this light, a questionnaire was chosen which comprised mainly behaviour-based items with a strong face validity. At the time of the research, several assertiveness measurement tools existed but there was only one that had been used specifically with drug addicts. It was therefore decided to use this questionnaire. Each of the items in the questionnaires was checked for its suitability in Saudi context. For example, in the assertiveness questionnaire questions 5, 17, 30 and 35 refer to dating and intimate relationships. Although the rituals around dating are very different in Saudi and the UK the questions were still deemed relevant because dating rituals do occur in Saudi Arabia but are much more covert.

In order to measure the extent to which participants possessed social skills, and assertiveness in particular, the Callner and Ross (1976) Assertion Questionnaire (AQ) was employed. The instrument measures

six different assertion areas:

- (1) Heterosexual: heterosexual interaction problems (i.e., interacting with the other sex). **Items No: (5) (11) (17) (23) (30) (35).**
- (2) Authority: interaction with authority figures (i.e., talking to a prospective employer at job interview, asking a boss for a salary increase, talking to a teacher or policeman). **Items No: (4) (10) (16) (29) (38).**
- (3) Positive Feedback: expressing and receiving praise. (i.e., taking compliments and communicating praise to other people). **Items No: (1) (7) (13) (19) (26) (32).**
- (4) Negative Feedback: expressing and responding to criticism. (i.e., responding to ridicule, providing constructive and non-derogatory criticism, and defending one's interests and beliefs from criticism by others). **Items No: (2) (8) (14) (20) (27) (33) (36).**
- (5) Drugs: assertion problems relating to drugs (i.e., turning down drug offers in a variety of situations ranging from telephone conversations to face-to-face street offers. **Items No: (3) (9) (15) (21) (28) (37).**
- (6) General Assertion: not related to specific assertion situations. **Items No: (6) (21) (18) (24) (25) (34) (39) (40).**

Six multiple choice items for each assertion area were generated. All items were based on a Likert, four-alternative format. This questionnaire consists of 40 items which were written in the form of statements that required the participant to rate each one as descriptive or not descriptive of him/her according to a four-point scale with no centre point. Scored in this manner, high positive scores represented extreme non-assertive ratings. Total score (40 items) on this scale potentially ranges from -80 to +80; assertion content area scores (six items per area score) varied from -12 to +12; and general assertion area score (10 items) varied from -20 to +20.

3.5.1. Factor Analysis

The Callner and Ross (1976) scale seemed somewhat dated, but since no better measurement for these purposes was discovered in the literature, it was deemed necessary to re-analyse both questionnaire data sets for all samples by means of factor analysis, in order to provide construct validity. In order to examine the underlying factor structure, principal components analysis with oblimin rotation was employed. Examination of the scree plot suggested four factors, each of which accounted for more than 5% of the variance and had Eigen values of higher than 2, see Table Seven below.

Table Seven: Factors, Percentage Of Variance And Eigen Values

<i>FACTORS</i>	<i>EIGEN VALUE</i>	<i>VARIANCE (%)</i>
<i>1</i>	7.31	18.3 %
<i>2</i>	3.02	7.6 %
<i>3</i>	2.27	5.7 %
<i>4</i>	2.01	5.0 %

Together, the factors accounted for 36.6% of the observed variance. Table Eight next page shows factor loadings, commonalities, validity and percentage of variance accounted for.

Table Eight: Factor Loading, Commonalities And Percentages Of Variance

ITEMS	FACTOR (1) (Emotional)	FACTOR (2) (Drugs)	FACTOR (3) (Fear / Confrontation)	FACTOR (4) (Behavioral Patterns)
<i>1- compliment</i>			.37	
<i>2- bad service</i>		-.20	-.32	.32
<i>3- no drugs</i>		.58		
<i>4- express opinion</i>			-.46	
<i>5- go for date</i>	.66			
<i>6- go & find friends</i>	.23			
<i>7-what I like</i>	.27			-.39
<i>8- criticism</i>			-.64	
<i>9- group meeting</i>		.30		
<i>10- asking for rise</i>		.20		-.55
<i>11-not out-going</i>	.58			-.30
<i>12- never leader</i>	.31			-.21
<i>13-don't say nice things</i>			-.65	
<i>14- the queue</i>			-.60	
<i>15- reject drug</i>		.70		
<i>16- hesitate calling</i>			-.52	.22
<i>17- move towards me</i>	.36	.24		
<i>18- following is better</i>		.25	-.49	
<i>19- paying compliment</i>		.31	-.28	
<i>20- parking place</i>				.50
<i>21- more assertive</i>		.48		
<i>22- speeding</i>				.57
<i>23-start conversation</i>	.83			
<i>24- more confident</i>	.28	.31	-.43	

<i>25- asking questions</i>		.47		.38
<i>26- depressed friend</i>		-.33		.77
<i>27- during argument</i>			-.23	.52
<i>28- 2b offered drink</i>		.70		
<i>29- apply for job</i>	.22			.65
<i>30- show affection</i>	.80			
<i>31- keep my feelings</i>	.48	.24		
<i>32- embarrassed</i>	.41			.34
<i>33- walk away</i>			-.29	.60
<i>34 –closed /feelings</i>	.39			.42
<i>35 –fear rejection</i>			-.61	
<i>36- take advantage me</i>		.46		.27
<i>37- refusing drugs</i>		.63		
<i>38- authority</i>			-.44	
<i>39- shy person</i>				.55
<i>40- open/opinions</i>			.23	.57
<i>VARIANCE</i>	16.6 %	8.9 %	6.2 %	5.8 %

(Factor loadings for items listed that did not load on factor one or two have been omitted.)

3.5.2. Reliability Analysis

Factor One, consisting of five items, yielded a Cronbach's alpha of .7048.

Factor Two, consisting of nine items, yielded a Cronbach's alpha of .6612.

Factor Three (seven items) produced Cronbach's alpha of .7682.

When all items are measured as a scale, a Cronbach's alpha of .8738 can be observed.

3.5.3. Materials: Personal History Form

The Personal History Form was formulated to record demographics (as already presented in the participants section) but also, in addition to that, a detailed history of the following:

- Information concerning children
- Did the participant run away from home?
- When did the participant first use? For the second time? Subsequently?
- Has the participant contemplated suicide? If yes, reason why
- Criminal record
- Sexuality
- Variety of drugs used
- Information about parental drug use
- Information about childhood trauma
- Religiosity
- Happiness and well-being

This information is important, as it can be used to explore patterns and associations between the groups, leading to a potential ‘causal’ explanation for the phenomena observed.

Data were entered into SPSS files, and subsequently analysed testing the hypotheses. These and their subsequent results can be found in the following chapter.

CHAPTER FOUR: ADDICTION, ALIENATION AND ASSERTIVENESS - QUANTITATIVE RESULTS

4.1 INTRODUCTION

The results section will be divided into two parts. The first part deals with the differences between English and Saudi controls and drug users; the second one addresses cultural differences in English and Saudi drug users. The following hypotheses are tested:

H1: drug addicts will have a higher degree of alienation in comparison to non-addicts.

H2: drug addicts will be less assertive than non-addicts.

H3: cultural differences will be detected between English and Saudi samples.

4.2. DIFFERENCES IN ALIENATION AND ASSERTIVENESS BETWEEN UK AND SAUDI CONTROLS AND DRUG USERS

The mean scores and standard deviations for English and Saudi drug users and controls on the two main variables (assertiveness and alienation) and their respective sub-scales are shown in Table Nine next page.

Table Nine: Mean Scores and Standard Deviations of English and Saudi Drug Users and Controls on Assertiveness and Alienation Totals and Sub-Scales

	<i>English</i>			<i>Saudi</i>	
	In-patients (n=21)	Out-patients (n=12)	Controls (n=26)	In-patients (n=83)	Controls (n=30)
<u><i>Alienation</i></u>					
<i>Total</i>	69.19	63.00	100.33	77.33	76.10
	(11.12)	(21.30)	(14.55)	(16.63)	(13.01)
<i>Self</i>	8.10	30.33	49.33	42.69	41.90
	(8.81)	(11.00)	(6.96)	(9.47)	(6.89)
<i>Social</i>	39.62	32.67	51.00	34.96	34.20
	(11.19)	(10.88)	(8.64)	(9.13)	(8.00)
<u><i>Assertiveness</i></u>					
<i>Total</i>	117.05	113.33	140.75	104.63	103.79
	(21.55)	(39.11)	(20.03)	(16.21)	(15.41)
<i>Behavioural</i>	51.57	46.17	56.00	35.46	34.00
	(8.53)	(14.17)	(8.41)	(9.08)	(6.47)
<i>Confrontational</i>	34.43	28.33	34.79	30.91	33.23
	(6.65)	(12.02)	(6.12)	(6.82)	(4.94)
<i>Drugs</i>	8.10	14.00	23.58	15.18	16.80
	(2.84)	(5.10)	(5.84)	(4.68)	(4.69)
<i>Emotional</i>	22.95	24.83	26.38	22.35	20.38
	(7.10)	(10.37)	(6.12)	(7.12)	(6.22)

Comparisons between drug users and controls were conducted separately for each nationality, as cultural differences might confound differences between these groups. Comparisons were made using non-parametric tests. These were chosen because, in some cases, samples show evidence of bi-modal or skewed distributions. Also, the homogeneity of variance assumption is violated in some of the comparisons. Whilst parametric tests have been shown to be reasonably robust when assumptions are violated, non-parametric tests were indicated here, given that some of the samples had clear outlying scores on some of the measures.

4.2.1. Alienation

4.2.1.1. The English Sample

As predicted, Table Nine above indicates that, in the English sample, controls are less alienated than in- and out-patients on the total alienation score and the two sub-scales (self and social). Three Kruskal-Wallis tests were conducted to examine the significance of the difference. Results are presented in Table Ten below.

Table Ten: Kruskal-Wallis Comparisons between English Controls, In-And Out-Patients on Alienation (Total, Self, Social)

	<i>df</i>	<i>chi-square</i>	<i>p</i>
<i><u>Alienation</u></i>			
<i>Total</i>	2	31.91	0.0001
<i>Self</i>	2	32.88	0.0001
<i>Social</i>	2	20.18	0.0001

Note: All chi-squares are corrected for ties

This shows that, as predicted, there is a significant difference between controls and drug users on the total alienation scale and the two sub-scales, self and social.

4.2.1.2. Saudi Sample

Table Nine above indicates that there is very little difference in alienation between Saudi drug users and controls. The differences are in the opposite direction to the one predicted. Mann-Whitney U tests were computed to compare the samples. The results are presented in Table Eleven next page.

Table Eleven: Mann-Whitney U Comparisons between Saudi Controls and Drug Users on Alienation (Total, Self and Social)

	<i>Mann-Whitney U</i>	<i>P</i>
<u><i>Alienation</i></u>		
<i>Total</i>	977	.3953
<i>Self</i>	1011	.2709
<i>Social</i>	1051.5	.2672

Note: probabilities are one-tailed and corrected for ties.

This shows that, for Saudi sample, there are no differences between controls and drug users in terms of alienation. The results for the English and Saudi samples are conflicting. Only the English drug users are more alienated than the controls.

4.2.2. Assertiveness

4.2.2.1. The English Sample

Table Eleven above indicates that the controls are more assertive than drug users on all assertiveness sub-scales. Kruskal-Wallis tests were computed to test the significance of these differences. The outcome is shown in Table Twelve next page.

Table Twelve: Kruskal-Wallis Comparisons of Assertiveness (Total and Sub-Scales) Between English Samples (Controls, In- And Out-Patients)

	<i>df</i>	<i>Chi-square</i>	<i>P</i>
<u>Assertiveness</u>			
<i>Total</i>	2	10.98	.0041
<i>Behavioural</i>	2	4.56	.1022
<i>Confrontational</i>	2	3.11	.2104
<i>Drugs</i>	2	38.25	.0001
<i>Emotional</i>	2	2.69	.2596

Note: All chi-squares are corrected for ties.

These results indicate that the English controls are more assertive than drug users on the total assertiveness scale and the drugs sub-scale. There are no significant differences on the other three sub-scales: behavioural, confrontational and emotional. It seems that the drugs sub-scale accounts for the significant difference observed at the level of the total assertiveness scale.

4.2.2.2. Saudi Sample

Table Thirteen: Mann-Whitney Comparisons of Assertiveness between Saudi Controls and Drug Users

	<i>Mann-Whitney U</i>	<i>p</i>
<u>Assertiveness</u>		
<i>Total</i>	980.5	.3953
<i>Behavioural</i>	1002	.1663
<i>Confrontational</i>	902.5	.569
<i>Drugs</i>	945	.606
<i>Emotional</i>	957	.111

Note: Probabilities are corrected for ties and one-tailed

Contrary to expectation, these results indicate that there are no significant differences between controls and drug users in the Saudi sample.

Overall, no differences were found in the Saudi sample on alienation or assertiveness. This may be due to several factors, not least social desirability or cultural differences.

4.3. CULTURAL DIFFERENCES IN UK AND SAUDI DRUG USERS

Table Fourteen: Mean Scores and Standard Deviations of English and Saudi Drug Users and Controls on Assertiveness and Alienation Totals and Sub-Scales

	<i>English</i>			<i>Saudi</i>	
	In-patients (n=21)	Out-patients (n=12)	Controls (n=26)	In-patients (n=83)	Controls (n=30)
<u>Alienation</u>					
<i>Total</i>	69.19	63.00	100.33	77.33	76.10
	(11.12)	(21.30)	(14.55)	(16.63)	(13.01)
<i>Self</i>	8.10	30.33	49.33	42.69	41.90
	(8.81)	(11.00)	(6.96)	(9.47)	(6.89)
<i>Social</i>	39.62	32.67	51.00	34.96	34.20
	(11.19)	(10.88)	(8.64)	(9.13)	(8.00)
<u>Assertiveness</u>					
<i>Total</i>	117.05	113.33	140.75	104.63	103.79
	(21.55)	(39.11)	(20.03)	(16.21)	(15.41)
<i>Behavioural</i>	51.57	46.17	56.00	35.46	34.00
	(8.53)	(14.17)	(8.41)	(9.08)	(6.47)
<i>Confrontational</i>	34.43	28.33	34.79	30.91	33.23
	(6.65)	(12.02)	(6.12)	(6.82)	(4.94)
<i>Drugs</i>	8.10	14.00	23.58	15.18	16.80
	(2.84)	(5.10)	(5.84)	(4.68)	(4.69)
<i>Emotional</i>	22.95	24.83	26.38	22.35	20.38
	(7.10)	(10.37)	(6.12)	(7.12)	(6.22)

Table Fourteen indicates that the Saudi drug users are less alienated than English out-patients. The differences appear to be on the self-alienation sub-scale. In terms of total assertiveness scores, both cultures

appear not to be similar. However, the cultural differences between Saudis and English patients are in different directions depending on the sub-scales. In Table Fifteen below, alienation of English in- and out-patients and Saudi out-patients is compared overall and on different sub-scales.

Table Fifteen: Kruskal-Wallis Comparisons between English (In- And Out-Patients) and Saudi (In-Patients) Drug Users on Alienation

	<i>df</i>	χ^2	<i>P</i>
<u>Alienation</u>			
<i>Total</i>	2	10.96	.0042
<i>Self</i>	2	29.49	.0001
<i>Social</i>	2	4.70	.0956

Note: All χ^2 are corrected for ties.

Although a non-parametric test was used to compare the groups, a series of Analyses of Variance was conducted, followed by Tuckey's Post-hoc comparisons, to locate the difference. This revealed that the Saudi in-patients are significantly less alienated (total score) than the English out-patients, but they are not significantly different from the English in-patients. This might be due to a more 'holding' environment provided by the institutions. Alienation would be more strongly felt on the streets than among peers in treatment centres. However, on the self-alienation sub-scale, the Saudi in-patients were significantly different from both English in- and out- patients. No significant differences were found on the social alienation sub-scale. The differences in assertiveness between Saudi and English drug users are presented in Table Sixteen below.

Table Sixteen: Kruskal-Wallis Comparisons between English and Saudi Drug Users on Assertiveness

	<i>df</i>	χ^2	<i>P</i>
<u>Assertiveness</u>			
<i>Total</i>	2	5.23	.0731
<i>Behavioural</i>	2	32.37	.0001
<i>Confrontational</i>	2	4.10	.1285
<i>Drugs</i>	2	32.32	.0001
<i>Emotional</i>	2	.90	.6354

Note: All χ^2 are corrected for ties.

There is no overall significant difference between Saudi and English drug users on the total assertiveness scale. However, there are significant differences on the behavioural and drugs sub-scales. Tukey's Post-hoc comparison reveals that Saudis are significantly less assertive than both English in- and out-patients. However, there is not a significant difference between the English in- and out-patients. There is also a significant difference on the drugs sub-scale, but in the opposite direction to the previous one. Tukey's Post-hoc comparisons reveal that the English in-patients are significantly less assertive than both the English out-patients and the Saudi in-patients. However, there is no significant difference between English out-patients and Saudi in-patients. There are no significant differences between the three groups on the confrontational and emotional sub-scales.

4.4. CULTURAL DIFFERENCES IN CONTROL GROUPS

The means and standard deviations of the English and the Saudi controls on Alienation and Assertiveness and their respective sub-scales are shown in columns three and five.

Table Seventeen: Mean Scores and Standard Deviations of English and Saudi Drug Users and Controls on Assertiveness and Alienation Totals and Sub-Scales

	<i>English</i>			<i>Saudi</i>	
	In-patients (n=21)	Out-patients (n=12)	Controls (n=26)	In-patients (n=83)	Controls (n=30)
<u>Alienation</u>					
<i>Total</i>	69.19	63.00	100.33	77.33	76.10
	(11.12)	(21.30)	(14.55)	(16.63)	(13.01)
<i>Self</i>	8.10	30.33	49.33	42.69	41.90
	(8.81)	(11.00)	(6.96)	(9.47)	(6.89)
<i>Social</i>	39.62	32.67	51.00	34.96	34.20
	(11.19)	(10.88)	(8.64)	(9.13)	(8.00)
<u>Assertiveness</u>					
<i>Total</i>	117.05	113.33	140.75	104.63	103.79
	(21.55)	(39.11)	(20.03)	(16.21)	(15.41)
<i>Behavioural</i>	51.57	46.17	56.00	35.46	34.00
	(8.53)	(14.17)	(8.41)	(9.08)	(6.47)
<i>Confrontational</i>	34.43	28.33	34.79	30.91	33.23
	(6.65)	(12.02)	(6.12)	(6.82)	(4.94)
<i>Drugs</i>	8.10	14.00	23.58	15.18	16.80
	(2.84)	(5.10)	(5.84)	(4.68)	(4.69)
<i>Emotional</i>	22.95	24.83	26.38	22.35	20.38
	(7.10)	(10.37)	(6.12)	(7.12)	(6.22)

The differences in assertiveness between English and Saudi controls are presented in Table Eighteen next page.

Table Eighteen A: Mann-Whitney Comparisons Between English And Saudi Controls On Alienation

	<i>Mann Whitney U</i>	<i>P</i>
<u>Alienation</u>		
<i>Total</i>	80.00	.0001
<i>Self</i>	166.00	.0004
<i>Social</i>	60.50	.0001

Note: probabilities are one-tailed and corrected for ties.

Saudi controls are significantly more alienated than the English controls.

Table Eighteen B: Mann-Whitney Comparisons Between English And Saudi Controls On Assertiveness

	<i>Mann-Whitney U</i>	<i>P</i>
<u>Assertiveness</u>		
<i>Total</i>	45.5	.0001
<i>Behavioural</i>	15.5	.0001
<i>Confrontational</i>	315	.2162
<i>Drugs</i>	125	.0001
<i>Emotional</i>	175	.001

Note: probabilities are one-tailed and corrected for ties

Table Eighteen shows that Saudi controls are significantly more alienated and less assertive than English controls.

This could again indicate either lack of validity of the questionnaire or genuine cultural differences. In view of the differences in the control samples, not much can really be made of the smaller differences between the drug user samples. Perhaps the conclusion should be that there are cultural differences irrespective of drug use.

4.5. CORRELATIONS BETWEEN ALIENATION AND ASSERTIVENESS

Correlations (Spear's) between Alienation and Assertiveness were computed for the five samples separately. They are reported in Table Nineteen below.

Table Nineteen: The Correlation Between Assertiveness And Alienation

<i>Sample</i>	<i>R</i>	<i>P</i>
<i>Saudi in-patients</i>	.29	.024
<i>English in-patients</i>	.15	.50
<i>English out-patients</i>	.79	.002
<i>Saudi controls</i>	.43	.019
<i>English controls</i>	.38	.067

Note: A positive correlation indicates an inverse relationship between Alienation and Assertiveness

The correlations were all in the same direction, i.e., high assertiveness was associated with low alienation. They are, however, significant only for Saudi in-patients and controls and English out-patients.

4.6. CONCLUSION

It is only the English sample of drug users that appears to conform to the predictions. Significant differences arise because Saudis appear to be less alienated, in particular, less self-alienated. The differences in assertiveness (which are not significant in any case) may be due to general cultural differences between the two societies. If the control groups are scrutinised, two further observations can be made. Saudi control group is significantly more alienated and less assertive than the English control group. This indicates either lack of validity of the

questionnaire in use on Saudi samples, or genuine cultural differences. In view of the differences in the control samples, nothing much can be made of the smaller differences between the samples.

4.7. DISCUSSION OF THE RESULTS

4.7.1. Hypothesis One: Drug Addicts Will Have A Higher Degree Of Alienation In Comparison With Non - Addicts

4.7.1.1. Differences In Alienation Between UK Drug Users And UK Controls

The main result showed that there was a clear difference between controls on the one hand and drug users on the other hand (both for the in-patient and out-patient groups). With respect to the total alienation score, the drug users were more alienated than the control group. Differences were not found within the two English drug user groups, although a Mann Whitney U test could be executed to detect possible individual differences. In fact, the mean alienation scores indicate for these two groups that the out-patients seem to be slightly more alienated than the in-patients. If one expects alienation to be linearly related to drug status, i.e., the degree of dependence on drugs, or inversely related to progress and treatment and rehabilitation, then one would expect the alienation to be greatest for in-patients, followed by out-patients, and subsequently controls.

Possible alternative interpretations could be that the in-patients, however, have a sense of belonging, as the institutionalised nature of their rehabilitation and treatment programme is executed within a safe and holding environment. The treatment setting evokes a sense of rightful belonging: anything that is expected from them can be fulfilled. What is meant by that is that they are in a clearly defined setting, with all the necessary role prescriptions, i.e., the ‘drug-user-patient-who-will-be-cured’, the ‘recipient-of-help’ and so on. Aspects such as the regularity of

treatment, the fixed nature of organizational proceedings, such as mealtimes, are influential, as is the omnipresence of health care professionals.

This position is contrasted with the situation of the out-patient who is struggling in a relatively hostile environment where difficulties are experienced carving out and defining a role, exacerbated by such variables as a potentially unstable home environment, an un-empathic social environment, and the economic pressures that drug use entails. Unemployment is likely to be a feature of the addict's life. Here, the importance of work in giving people a sense of meaning and belonging cannot be overestimated.

This interpretation is supported when one explores the scores of in- and out-patients on the alienation sub-scales, self-alienation and social alienation. Again, the drug user groups are more alienated on both these sub-scales than the controls. The in-patients have a much more severe alienation score on the self sub-scale than the social sub-scale. On the other hand, the out-patients have similar self-alienation and social alienation scores. In addition, the in-patients are less alienated on the social score than the out-patients, which is consistent with the above interpretation, i.e., indicating that the social support provided in the treatment setting is having an effect on their social alienation score, while the out-patients are facing more socially alienating situations outside the protective parameters. It is interesting also to note that, on the self-alienation score, the in-patients are much more alienated than the out-patients, who in turn are more alienated than the controls.

Thus, the expectation of a linear relationship between treatment status (ranging from in-patients to out-patients and controls) seems to hold for self-alienation only, while the hostile environment faced by out-patients as they leave the treatment centre may be responsible for a turn for the worse on their social alienation scores.

4.7.1.2. Differences In Alienation Between Saudi Drug Users And Saudi Controls

As far as the Saudi sample is concerned with respect to alienation, no significant differences were observed on any of the alienation scales (total, self and social) between the in-patients group and the control group. The scores were in fact almost exactly the same for both groups on all three scales. With reference to the UK sample described above, and to the previous literature, one would have expected alienation to be greater for the in-patients. However, this was not confirmed. The question arises as to whether the instruments used to measure alienation are equally valid for use in Saudi Arabia and the UK.

While factor analyses presented earlier do give an indication that they are valid, this validity only pertains to the internal structure of the measurement instrument. External validity, i.e., the confirmation that alienation as a construct or concept exists in the Arab psyche, has not been demonstrated. To establish whether the same factor structure of alienation items is observed in Saudi Arabia as in the UK, a separate factor analysis would need to be conducted on the Saudi sample alone. However, the participant numbers do not permit such analysis. Hierarchical cluster analysis might be a method worth exploring under these circumstances to facilitate the exploration of the underlying structure of both Saudi and UK alienation factors separately.

It may well be that alienation as a phenomenon does not exist in the same sense as it does in the UK. However, it could also be a distinct possibility that the Saudi drug users are simply not alienated, i.e., that drug dependency in the Saudi culture does not have a relationship with alienation. If it is claimed that alienation is causally linked to drug use, then this clearly does not hold for the Saudi sample. It could be claimed that by undergoing treatment in a treatment centre, their initial alienation has sufficiently subsided to a similar level as that experienced by a control population (for instance, through religious activity).

It would be useful in subsequent investigations to document how far into the treatment programme patients had advanced. As was mentioned earlier when the differences in treatment between the UK and the Saudi Arabian context were discussed, the Saudi treatment programme appears to be very intensive and compulsory, as opposed to UK programmes where the choice of treatment often involves the participatory decision making of the drug user.

In short, four potential explanations have been put forward for the lack of observed differences in alienation between Saudi drug users and control samples:

- (1) The lack of difference is due to uncertainties pertaining to the way alienation is measured. More work needs to be done to validate the appropriateness of the questionnaire instrument for assessing alienation in Saudi culture. An initial step would involve an exploration of the factor structure.
- (2) The lack of difference is due to the non-existence of the alienation phenomenon in Saudi culture. Further work in this area might include a qualitative study exploring the views held and expressed (or the lack thereof) about the alienation concept.
- (3) The lack of difference is due to a quick rehabilitation from previously experienced alienation, alleviated by the effectiveness of the treatment programme. To address this issue, a longitudinal or cross sectional study could be conducted, assessing or monitoring the progressive change in alienation (or decrease) as the treatment programme unfolds.
- (4) The lack of difference is due to the fact that the Saudi sample is not alienated. Cultural variables which might mediate in this area will be fully discussed when Hypothesis Three is examined. This may also

relate to the nature of the samples in the versus those in the UK. It is a distinct possibility that the drug users in both places are drawn from distinctly different societal strata (as the Personal History Form demonstrates in Chapter Four).

4.7.1.3. Conclusion On Hypothesis One

The support for the first hypothesis that drug users will have a higher degree of alienation in comparison to non-addicts is conflicting. It is supported with respect to the UK sample: alienation is higher for the drug users on all alienation scales. There are also indications that social alienation increases slightly for drug users who are not in a treatment setting. In the Saudi sample, however, no differences were observed between drug users and controls. Further avenues for research are suggested.

4.7.2. Hypothesis Two: Drug Addicts Will Be Less Assertive Than Non - Addicts

4.7.2.1. Differences In Assertiveness Between UK Drug Users And UK Controls

Assertiveness was measured on five scales (total, behavioural, confrontational, drugs and emotional). It was predicted that drug users would be less assertive than controls. This hypothesis was confirmed on two scales, the total and the drugs sub-scale, where a significant difference was observed. The difference was also in the predicted direction on all three other sub-scales. Differences between in-patients and out-patients on assertiveness do not indicate, however, a linear increase in assertiveness as the treatment progresses. Further studies would need to be conducted to ascertain if there are differences between in- and out-patients, but the main finding holds, i.e., that assertiveness is greater in controls than drug users. Significant differences were observed on the drugs assertiveness sub-scale only (in addition to the total

assertiveness scale). This is to be expected, as the drug users are obviously using drugs; hence they are demonstrating a lack of assertiveness with respect to drugs.

It could be inferred from this that assertiveness in general might not be an issue for drug users, as they are no different on the other assertiveness sub-scales (behavioural, confrontational and emotional). The significant differences observed on the total assertiveness scales can be accounted for by the observed variance in the drug assertiveness sub-scale. This might lead to the conclusion that a phenomenon other than assertiveness is responsible for drug use. This study is of course correlational, and causal inferences would not be possible, but these results do not indicate that an exploration of causal relationships between assertiveness (or lack of it) and drug use is a fruitful avenue.

Given, however, that all three sub-scales that did not show significant differences between drug users and controls are in the expected direction, i.e., controls are slightly more assertive than the drug users, then it could be that with increased participant numbers this tendency might be shown to be significant.

4.7.2.2. Differences In Assertiveness Between Saudi Drug Users And Saudi Controls

Assertiveness on the five sub-scales was also compared in the Saudi sample of in-patients and controls. Contrary to expectation, no significant differences were observed in assertiveness between these two samples. In fact, scores on all sub-scales were almost identical. This shows a similar trend to that observed in the Saudi alienation comparisons.

This lack of difference goes against any theory linking lack of assertiveness to drug use or, put in causal terms, that drug use is caused by an overall lack of assertiveness. The reasons for this lack of difference are equally difficult to interpret. One possible explanation for the high

assertiveness scores of in-patients in comparison with controls could lie in the nature of the samples of drug users, i.e., there might be differences in assertiveness between the UK and the Saudi drug users. As explained in the treatment section in the Cross Cultural Chapter, the routes that lead to treatment are distinctly different in the UK than in Saudi Arabia.

In the UK, the admission to treatment is entirely voluntary: it is up to the individual to decide whether he or she seeks admission to a variety of programmes. In Saudi Arabia, on the other hand, admission is mandatory. Whoever refuses or hesitates to get help is sent to the treatment centre for the necessary treatment. Family members are also encouraged to report on relatives whom they suspect of having issues around drug use. This leads to a situation where it can be hypothesised that Saudi patients get treatment *earlier* on their developmental route as drug users in comparison with UK patients. It could be considered that UK drug users are more severely damaged psychologically than the typical Saudi treatment recipient. A deterioration of assertiveness might be one such psychological consequence of drug use.

An issue that cannot be ignored is the issue of social desirability. Assertiveness in Saudi culture is not a desirable trait; therefore, it might perhaps not be surprising that Saudi samples score lower on these scales. As both controls and drug users scores are very similar, the effect is arguably attributable to an overall cultural effect rather than internal, cognitive differences between the samples.

4.7.2.3. Conclusion On Hypothesis Two

The support for the second hypothesis that drug users will be less assertive than non-users is conflicting. It is supported with respect to the UK sample: assertiveness is significantly lower for the drug users on the total assertiveness scale and on the drugs assertiveness sub-scale, but not on the behavioural, confrontational and emotional assertiveness scales. In the Saudi sample, however, no differences were observed between drug

users and controls. Further avenues for research are suggested.

4.7.3. Hypothesis Three: Cultural Differences Will Be Detected Between Saudi And UK Samples

4.7.3.1. Differences In Alienation Between Saudi Samples And UK Samples

Results of alienation scores were compared between Saudi drug users and UK drug users. A significant difference was found between the two groups on total alienation and an even larger significant difference on the self-alienation sub-scale. Saudi drug users are less alienated (particularly from self) than UK drug users. However, UK controls were significantly less alienated than Saudi controls. This points to the fact that there might be a difference in the effect observed that is not explained by cultural differences. Again, several potential explanations can be posited for this phenomenon if they are culturally different:

- (1) The lack of difference is due to uncertainties pertaining to the way alienation is measured. More work needs to be done to validate the appropriateness of the questionnaire instrument for assessing alienation in the Saudi culture. An initial step would involve an exploration of the factor structure.
- (2) The lack of difference is due to the non-existence of the alienation phenomenon in Saudi culture. This possibility is linked to the one expressed above. Further work in this area might include a qualitative study exploring the views held and expressed (or the lack thereof) about the alienation concept.
- (3) The lack of difference is due to a quick rehabilitation from previously experienced alienation, alleviated by the effectiveness of the treatment programme. To address this issue, a longitudinal or

cross sectional study could be conducted, assessing or monitoring the progressive change in alienation as the treatment programme unfolds.

- (4) The lack of difference is due to the fact that the Saudi sample is not alienated. Cultural variables might mediate in this. This may also be related to the nature of the samples in Saudi Arabia versus the UK. It is a distinct possibility that the drug users in both places are drawn from distinctly different societal strata.

Yet another possible explanation for this is offered through the concept of 'choice'. In the UK, drug users are offered 'choice' about their treatment, whereas in Saudi treatment is in the hands of the authorities and is mandatory. In general, life in the UK appears to be more open to choice (hence, perhaps the lowest alienation scores of the UK controls). In Saudi culture, life is governed by dominant (sometimes implicit) codes of conduct that rule behaviour (as laid out by Islamic Law). This could contribute to the alienation differences between the two control samples, but also between the drug samples, as the shift in choice is not as great in Saudi Arabia as is the shift in the UK. Taken on a national scale, we could argue that locus of control in the Saudi context is external, while in the UK it is internal.

4.7.3.2. Differences In Assertiveness Between Saudi Samples And UK Samples

As mentioned above under the previous hypotheses, it was not surprising that the drugs assertiveness sub-scale accounted for the variance in explaining the difference between drug using and control samples. However, when comparing these results cross-culturally, a significant difference was observed between the Saudi drug users and the UK drug users, the Saudi drug users being less assertive on the behavioural assertiveness sub-scale. A similar, but much higher, significant difference was observed when comparing the control samples.

In general, it can be concluded, then, that the variability in assertiveness, particularly on the behavioural assertiveness sub-scale, is accounted for by differences in culture, rather than related to the use of drugs.

To refer back to what was discussed under alienation, the lack of assertiveness in terms of behaviour supports the notion of 'choice' (or lack thereof). Is 'choice' the concept that warrants most further investigation, and/or is it a 'third variable' that accounts for the observed differences in this study? Again, the notion of locus of control could be useful here.

4.7.3.3. Conclusion On Hypothesis Three

As the effects of all hypotheses show that they apply only to the UK samples and not to the Arabian samples, cultural differences probably account for this phenomenon. In some ways this is not surprising: assertiveness and alienation are distinct Western concepts; they were operationalised for use in a Western society, and may therefore not apply in the Middle East. A qualitative study exploring the meaning attributed to phenomena such as alienation and assertiveness, and their possible link with drug addiction, would shed some more light on this. Future research ought to take these findings into account; it is likely that a psychosocial phenomenon is always to a certain extent context specific, and even more so when a totally different culture with all its vicissitudes is being investigated.

4.8 REFLECTIONS ON CROSS-CULTURAL VALIDITY

In part, the results observed here may be the result of the lack of validity of the instruments used with these samples. The nature of cross-cultural research is by definition comparative, and as such it is important that the instruments used are measuring in both what they purport to measure in both cultures. As Van de Vijver and Leung (1997) point out, cross-cultural studies are susceptible to measurement artifacts. In particular, they point to how research questions are formulated and how

constructs are measured. Apart from the factor analysis, great care was taken to ensure that all items on the questionnaire had strong face validity. However, it is not certain that participants of different cultures attribute similar meanings to these questionnaire items. For instance, it could be argued that in a Western culture the notion of being assertive is regarded as positive, whereas in a Middle Eastern context it is more aligned with notions of disobedience. Indeed, the whole concept of being active or passive may have radically different connotations in these two cultures. Returning briefly to the factor analysis, it was shown that the factor solution did not replicate the original factors reported for both alienation and assertiveness, thus strongly indicating that the validity of these instruments for the purposes of this study was limited. In addition, it could be argued that taking a positivist perspective was not an appropriate research design at all. Berry *et al.* (2002) point out that while the method could be very useful when conducting experiments, reducing measurement from the observable realities of the experimental conditions to the vastly more subjective conditions of the survey severely limits the benefits of positivist research. The following section will review some relevant studies on the role of validity in cross-cultural studies.

Evidence regarding cross-cultural validity of instruments is conflicting. Some researchers argue that it is indeed possible to use the same instruments across different cultures unproblematically, whereas others point to some serious flaws. On the positive side, Woerner, Fleitlich-Bilyk, Martinussen, Fletcher, Cucchiaro, Dalgarrondo, Lui and Tannock (2004) examined the cross-cultural validity of the Strengths and Difficulties questionnaire (SDQ), and found sound support for the psychometric properties and clinical utility for this questionnaire across a huge variety of cultures. Bendania and Abed (1997) reported similar findings for the Self Consciousness Scale (Fenigstein, Scheier and Buss, 1975). They found that when this instrument was used in the United Arab Emirates, factor analyses produced the same general factors as in the original Western and other replicating studies. They conclude

therefore that this instrument is culturally sensitive, as the factor structure is both stable and allows for the observation of different distributions of items over factors. A third example of successful cross-cultural validation is the Beck Depression Inventory. West and Al-Kaisi (1985) present a study conducted with this instrument in Saudi Arabia, and report that the results of the cross-cultural validation agree favourably with those of the original American validation.

However, Al-Musawi (2003), in a study examining validation of the Arabic version of the Group Personality Projective test in Bahrain, showed that the factor solutions obtained in the Arabic sample do not correspond to the original American factor structure. He therefore concludes that there is some considerable variance between the cultural groups in the US and Bahrain. Escandell (2002), in a thorough review of cross-cultural research with a particular emphasis on Saudi Arabia, stresses that the acquisition of local normative data stratified by age, sex, education, occupation and geographic region is the preferred method when using new instruments that show great sensitivity or selectivity but are from another culture. Local norms, he argues, give purpose to the measure. Many tests that short-circuit these methods are problematic, since there is no base rate against which to compare them. Indeed, this is a significant weakness of this present study. However, Escandell (2002) points out that collecting normative data takes a lot of time, money, and long-range planning, and acknowledges that it is therefore beyond the scope of many research projects. While not a valid excuse, it nevertheless explains why this may not always happen. A final interesting study examines the use of Rorschach amongst Iranian women (Aposhian, 1994). It is important to acknowledge that validity around the Rorschach is controversial anyhow, but this study does point to some interesting findings that highlight the extent to which lack of validity could lead to erroneous conclusions. Aposhian tested Iranian women on the Rorschach, one third receiving the intervention in Farsi using an Iranian female examiner, one third in English using a male American

examiner, and one third in English using a female American researcher. All three groups tested significantly different from Americans. In particular, an unusually large number were diagnosed as schizophrenic, clinically depressed, suicidal or with coping deficit. Hour-long follow-up interviews with these participants revealed none of the DSM criteria for these conditions. Indeed, clinicians who interviewed them found them in very good mental health. The implications for false positive diagnoses among Iranian women on this instrument are therefore significant, and point out clearly the dangers of drawing the wrong conclusions when an instrument is not validated for cross-cultural samples.

As it was beyond the scope of this study to establish comprehensive norms for the alienation and assertiveness instruments, and as the observed factor structures did not replicate, a different way of investigating these concepts with a Saudi sample is called for. Since it is evident that different meanings are attached to concepts such as alienation and assertiveness, it seems appropriate to conduct a phenomenological study. This allows for a more sophisticated investigation of meaning in a culturally sensitive way, as well as avoiding the methodological artifacts as described above (Smith, 2003).

CHAPTER FIVE: A QUALITATIVE INVESTIGATION OF SAUDI DRUG USE

5.1. INTRODUCTION

Quantitative questionnaire-based research has an important role to play in the mapping out and creation of understanding of culturally different groups. However, it could be argued that if one wants to gain a deeper level of understanding of a particular phenomenon such as drug addiction, qualitative methodologies offer richer data. It is the belief of this researcher that not a single study has been conducted in which Saudi drug users have been interviewed about their drug use. The reason for this is quite simple: The Kingdom of Saudi Arabia did not until recently officially admit it has drug users amongst its population. Drug users are very much seen as pariahs and conducting further research is not seen as particularly necessary.

Using a qualitative methodology heralds a shift from the dominant positivist paradigm hitherto adopted in this thesis. Within an interpretive research framework, the goal of the researcher is to gain a fuller understanding of the individual's situation and perspective rather than to interpret the relationships between diverse sets of variables. To a certain extent, the researcher ceases to be the dispassionate and detached observer and starts playing a more central role through her own interpretations. This is why it is important to be reflective regarding one's own position and sets of assumptions. As a researcher in this study, I have helped construct meaning, and do not assume a neutral position. I elaborate on this further when I discuss the lenses I used for analysing data.

5.2. PURPOSE OF THE STUDY

There are several purposes for conducting this study. Firstly, I wanted to explore the phenomena of addiction, alienation, and assertiveness in a Saudi context. As a result of the quantitative findings, it had become clear that a shared meaning did not exist in Saudi Arabia and UK regarding these concepts. This notion of shared meaning (or lack of) has become a prominent topic of discussion in the social sciences and mental health fields. Littlewood and Lipsedge (1997), when discussing the concept of 'mental illness', ask why different societies might have different conceptualizations. They postulate several possibilities: the failure to recognise a particular phenomenon because the diagnostic lens is not shared; the concept being culturally derived rather than objectively/scientifically defined, and a lack of attention to the function of different concepts in different contexts. Wanigaratne *et al.* (2001) equally point out that assumptions about a particular culture or ethnic group need to be carefully scrutinised, as they may result in erroneous assessments. They describe, for instance, the over-diagnosis of marijuana-induced psychosis in black Afro-Caribbean males. Indeed, Lloyd and Bor (2000), when discussing communication skills in clinical practice, point to the erroneous conclusions that can be drawn when too many assumptions are made regarding cultural and ethnic issues. They mention, for instance, that female health professionals may be perceived as having lower status by some ethnic groups, and therefore their opinions may not be valued as much as if they were male. Equally, they show that Western health professionals may interpret some behaviours as obstructive and uncooperative in patients from different ethnic groups, whereas these behaviours are in fact part of a social, cultural or religious code of conduct.

Littlewood and Lipsedge (1997), when discussing how different cultural backgrounds intersect with psychiatry as a profession, add that this is not solely a miscomprehension across cultures, but the legitimacy that is attached to the 'objective, scientific' knowledge of a discipline

that is regarded as hierarchically higher than knowledge that is derived locally, and within context. They give the example of a black Afro-Caribbean male being diagnosed by an Indian psychiatrist, working within a UK mainstream medical model, as schizophrenic, whereas the man was espousing beliefs that were shared by a large section of the Afro-Caribbean population. In this example, what would be considered normal in one cultural context becomes, through the application of a system of thought that is deemed objective and scientific (and therefore considered universally applicable and generalisable), not different but abnormal.

A good example of this can be found on the recent letter pages of the journal *Annals of Saudi Medicine* (2004) regarding heroin users and the use of religious therapy as treatment. Nayyer Iqbal, a Consultant Psychiatrist at the Al-Amal Hospital in Jeddah, accuses Anton Osman, a Neuroscientist at the King Faisal Hospital in Jeddah, of ‘minimising the role of religion in the recovery of addicts’. He acknowledges Osman’s claim that ‘religion lacks the objectivity of science’, but argues that ‘this does not imply that it has little or no therapeutic value’. He referred to a letter published by Osman and Shawoosh in the same journal (November 2003), where, amongst other things, they claimed religion to be unscientific and vague. Iqbal’s counter-claim is that religion is ‘under-researched, under-utilised and under-valued as a treatment modality’. As evidence, he quotes a 1997 study published in the *American Journal of Psychiatry* that conducted research into religion, psychopathology and substance use and abuse (Kendler, Gardner and Prescott, 1997). Referring to this work as ‘significant evidence’, he continues: “this supports the fact that religion does indeed offer protection against mental illness and addiction. There is therefore a need to bring objectivity to religion by developing and researching religious therapies and interventions. There is no better place than Saudi Arabia to do this”. In a ‘right to reply’ letter, Iqbal (2004) stated:

“I hope Dr Osman, as one of the consultants working in such a

specialised field, in a country with very deeply rooted religious adherence, should be more careful in what he writes about such a problem [minimizing the role of religion] to minimise the already mislead and mis-informed public about this problem [addiction]. We have stressed and emphasised the protective role of good adherence to religion in preventing self-destructive behaviour and addiction, but at the same time we have strongly advised against reducing the causes for such complex behaviour to socio-cultural factors only”, (:305)

Several conclusions can be drawn from this interesting interchange of letters. Firstly, there is evidence of Saudi Arabia becoming more open, if a discussion regarding religion can take place in the journals. Secondly, it involves the juxtaposition of two powerful and totalizing discourses – religion and science. Thirdly, there is an attempt to integrate Osman’s ideas – addiction cannot be understood by solely socio-cultural elements; and Iqbal’s use of scientific language to defend religion (under-researched; quoting prestigious scientific studies) and in effect to provide a scientific basis for religion. Fourthly, a ‘forward thinking’ and ‘developing’ agenda is put forward by Osman, following the discourse of progressive science (true to the Enlightenment spirit) versus a defence from Iqbal. Finally, it needs to be noted that Osman is a German professor researching in Saudi Arabia, whereas Iqbal is Saudi born and bred.

In short, this example illustrates the complexity of cultural, epistemological and ontological assumptions. To generalise somewhat, the ‘Western’ view being proposed holds that religion has a marginal role to play in treating addiction, that it is dangerous to hold that view, and that it is not scientific. The Middle Eastern view holds that religion is central, to minimise its importance is short-sighted, and effort should be applied to make religion and religious therapy more scientific. Of interest here is how a Middle Eastern culture seeks to legitimate its view by referring to a Western discourse on science. Conversely, some

Western researchers tend to go the other way: *“We would emphasise that these [religion as systems of understanding and creating personal identity] are the modes by which many, perhaps most, people in the world interpret and experience serious mental illness, reflecting complex local psychologies of selfhood, autonomy, causality and power. To denigrate the individual’s religious perspective as simply ‘lacking in insight’, whether we do this for reasons of biomedical positivism or vulgar Marxism, is to ignore both the intellectual elegance of religious explanation and its historical role in maintaining black identity in the face of European oppression, not to mention its pragmatic function in generating organizations which have taken on more overtly political concerns”*, (Littlewood and Lipsedge 1997 :ix-x).

In Saudi Arabia, this tension between the ‘traditional’ (i.e., religion) and the ‘modern’ (i.e., science) is central to how the country at present is re-examining itself. In particular, the younger generations are at the forefront of redefining the role of religion within a society that cannot avoid the gathering social and economic forces of a globalised world (Yamani, 2000). They contest notions of tradition and modernity, with no single definition holding common currency.

‘Science’, however, is still very much regarded as synonymous with quantitative work. While not explicitly stated, the absence of published qualitative work in Saudi journals could be seen to indicate that qualitative work at best is not as desirable as quantitative work, or at worst that it is considered unscientific. This would not be an uncommon view, as it echoes the UK debate within psychology regarding the scientific status of the ‘new paradigm’. As discussed above, the process of examining the traditional-modern dichotomy is ongoing, and, it is perhaps too soon to accept the post-positivist approach to scientific inquiry. Nevertheless, it is an approach that warrants further exploration at this time.

5.3. ADDICTION, ALIENATION AND ASSERTIVENESS IN A SAUDI CONTEXT

Since its creation in 1932, Saudi Arabia has undergone rapid and continuous social, economic and cultural transformation. Three generations have now lived under the rule of a specific Saudi state – the participants for this study come from the most recent or ‘new’ generation. This new generation perceived itself to be located between the institutions of the previous generation (family and religion, the ‘traditional’ institutions) and the newer institutions of market and state. The members of this new generation are the first to seriously question and engage in a re-examination of what it means to be ‘traditional’ and ‘modern’ (Yamani, 2000). As Yamani illustrates, the world views of this generation show that notions of tradition and modernity have become contested, with no single definition having common currency. For instance, they struggle with the redefinition of the role of religion within a society that cannot avoid the gathering economic and social forces of a globalised world. The perceptions and attitudes of this generation have been formed through engagement with a wider range of possibilities than was previously available : travel for work and leisure, education at home and abroad, a broad range of technological consumer goods, print and electronic media. As a result of these, there is a sense of inevitability about the growth of the modern in Saudi society. However, problems arise when there is a need to negotiate between the traditional Saudi social basis to life and the modern pressures seen as emanating from outside. Pre-existing cultural identities seem less and less able to encompass the kinds of social practices and social relations to which the state and market have increasingly given rise (Yamani, 2000). The main task facing the new generation of Saudis is the need to negotiate a sense of self in these new and unfamiliar circumstances.

5.3.1. Self-alienation: A Question Of Identity

As alluded to above, alienation in a Saudi context is not merely

being *removed* from self and society, but more of a *struggle* with self and society. Third-generation Saudis are faced with complex issues about who they are and what society they want to live in. Over the past few years, economic, political and religious behavioural standards have come under increasing pressure within the country. This has resulted in old standards of behaviour being either discarded or modified, a process that inevitably results in the changing of identity. Families are no longer the dominant sphere of socio-economic life; their role appears to be becoming gradually marginalised. Yamani (2000) points out that this can be observed in the current trend to idealise family, almost as a recognition of its diminished role. A similar argument can be made for religion. There is a shift in the relationship between religion and the more market-based social life. Religion either adjusts to this by becoming more permissive, or adopts a more rigorous enforcement of certain concrete social practices. Those who take tradition and community seriously argue that the state and family should see to it that the tensions between the old and new are minimised, and argue for a sense of national community – to preserve the traditional Saudi identity. Identity, whether conceptualised as a ‘given’ or ‘constructed’ is that which endows groups and individuals with a place, a function, a purpose and with a capacity for action (Dean, 1997). Identity is therefore indivisible from a political context. The basis of an individual’s identity within a given society is over-determined, being created from numerous sources. Each input gains or loses importance depending on the individual’s social circumstances. Since the founding of the state, Saudi identity has been determined by overlapping and competing sources (Yamani, 2000). Internal sources of competition have included religion, tribal belonging, family and the nation. External sources have encompassed the forces of Western modernization. The direction of this evolving sense of identity has been linked to the processes of economic development and government policy. The ruling elite has sought to control the process in ways that support its own political agenda and strengthen its position at the heart of the state. In times of economic

growth, the Saudi population, optimistic about the future and supported by a financially strong state, has received ideas from the outside world with a degree of confidence that facilitates their coherent assimilation. However, in times of economic uncertainty and government austerity (the current situation), the population as a whole tends to seek cultural reassurance in notions of tradition. They become preoccupied with the mosque and public displays of piety or the home village from where their grandparents came, or else they transfigure the meaning of tradition so that it fits more easily with the new world (Yamani, 2000). Either way, this retreat into certainty is an attempt to interact with a rapidly changing and uncertain world from a secure and recognisable base. As Erikson (1968) suggested, there is a need to relate the various aspects of one's life to one another in a coherent way. Reconciling these differences is a core part of the tasks faced by the new Saudi generation. I will argue here that some of the people in this sample used addiction to reconcile their fragmented sense of self and identity by adopting the cohesive identity of the drug user.

5.3.2. Asserting Self In A Muslim Society

In terms of assertiveness, the same tension between the traditional and the modern can be observed. Striking out in search of the modern, thus creating a new identity can be regarded as a counter-cultural act of defiance, demonstrating the will to do something that differentiates one's self. In this sense, using drugs becomes a very assertive strategy, along similar lines to that observed in the West during the Sixties – the drug user as rebel, rejecting traditional society, becoming a different person. Yet this will, or assertion, has also been used in the converse way, for instance in the 'just say no' campaigns against drugs in the US. In Saudi Arabia (as in most Muslim states), the dominant cultural norm is to be non-assertive, as one's will is not deemed important – it is Allah's will that matters, which is expressed clearly in the guidelines contained in the Quran. But as Littlewood (1998) emphasises, "there seems to be a tendency for industrialised societies with social mobility and a pluralistic

ideology to develop more individualised notions”. In the current climate of old versus new, with the impact of Western modernizing influences, it is perhaps not surprising that the focus shifts from the religious and communal to the individual. Asserting one’s self, whether against the state, family or religion, is frowned upon or even forbidden in the traditional way of life. The use of drugs, then, can be regarded as both an act of defiance and the seeking of a new identity at the same time. It is thoroughly modern, and results from conflict between the modern and the traditional.

5.4. METHOD AND ANALYSIS

5.4.1. Background To The Study

This study took place six years after the first, quantitative study had been completed. There were several reasons for this, both at a micro and macro level. Conducting research as a woman in Saudi Arabia is difficult. While tolerated, there is nevertheless a general view that this is an unnecessary activity for a woman to engage in, let alone give priority to. Any other obligations are deemed more important than the pursuit of a career or interest, in particular those connected with the family. Familial needs have to be addressed first, and since families tend to be extensive, women can spend considerable amounts of time attending to these obligations. Secondly, the general climate over the past decade has made the region more unstable. In times of instability, the pull from the family is even greater, and signs of independence are even more frowned upon. Yet, instability can also herald positive change, however tentative, and this was in evidence in the attitudes towards and treatment of drug users.

One advantage of the delay in completing the research, was that the situation regarding drugs had changed to a certain extent in Saudi Arabia. While drugs were still very much a taboo subject, more centres had opened, and there appeared to be more openness regarding the discussion and treatment of drug use. In particular, the opening of a centre in

Jeddah was significant. Jeddah has always had a more liberal attitude towards many social and political issues, in comparison to the conservatism of Riyadh. In part, this could be explained by the ethnic groups in the two regions. In Riyadh, the main population is made up of people originating from the Bedouin tribes, who are very conservatively religious. Most of the population in Jeddah is made up of third generation immigrants that originally came for Omrah or Pilgrimage (Hajj) and then took up residency. They brought with them a more liberal form of Islam. This tension in the country between moderately liberal reforming factions and the more staunchly traditional and conservative ones has increased in recent years, not least through the influence in the region of world events such as 9/11 and the two Gulf wars.

The Jeddah centre was therefore my first contact point for further research. Through a positive experience with the psychiatrist in this centre, I also received a referral to the sister centre in Riyadh, where I conducted my initial quantitative study.

5.4.2. Method: Interviews

The interview was chosen as an appropriate method as it would allow an in-depth, personal account of the genesis and experience of the drug user. As Burgess (1984) points out, interviews are conversations with a purpose. There are a variety of questioning strategies potentially available to the qualitative researcher. In this particular context, a primary aim was to encourage participants to “open up” and talk about themselves and their life experience. A questioning strategy which facilitated this seemed most likely to be effective, and left to the choice of a semi structured format, with open questions and probes (Hopkinson and Rutter 1981), rather than a highly direction strategy. This should ensure that there was sufficient space for the interviewees’ voices to come through. This allowed me to ask my key research question (“can you tell me why you started to use drugs”), accompanied by a series of

prompts (“can you tell me more about”), (“what other thoughts come to mind as we are discussing this”) to elicit more detailed information. By asking this very broad question I was able to set the agenda for the interview, without restricting the scope of the participants’ answers.

5.4.3. Recruitment Of Participants

The sample was an opportunity sample of drug users who were in-patients at two centres, the Al Amal centre in Riyadh and the Al Amal centre in Jeddah. I discussed the purposes of the study with the psychiatrists in charge of the two centres, and they asked for volunteers to participate. In total, 19 participants agreed to be interviewed, of which 7 withdrew at the time of interview (see discussion below), leaving a total of 12. The time table was coordinated by the social workers who worked with the participants on a day-to-day basis.

5.4.4. Procedure: Conducting The Interview

Participants were given a consent form, (following the British Psychological Society guidelines). The interview was scheduled for 90 minutes per participant, to allow for 15 minutes introduction and briefing regarding the study, and 15 minutes for a debriefing session at the end. Some interviews lasted for a considerably shorter time. I decided to ‘go with the flow’ rather than sticking to a rigid time structure, and therefore did not challenge interviewees inappropriately when they showed signs of being uncomfortable about the interview situation. It needs to be borne in mind that the participants I was working with did not have experience of being interviewed other than in either a medical or police/prison context, hence there was some distrust and apprehension. While it was made clear when participants were invited to participate in this study that they were participating in a research project and that participation was voluntary, there was still some apprehension. I therefore spent a prolonged time discussing the context of the interview, with specific reference to the following points:

- Purpose: I explained that the aims of the study were to gain more knowledge about drug use in Saudi Arabia, and to try and understand the reasons why people were taking drugs. I made it clear that I was not prejudiced or ‘blaming them’ for taking drugs – rather, that I wanted to find out more so we could potentially help people better in future should they experience problems with drugs. I emphasised that participation was voluntary, and would not affect their treatment at the hospital.
- Confidentiality: I explained that I had received permission from the psychiatrists in charge of the centres to conduct this research, and that I was under no obligation to report back what we discussed in the interview. However, as I am a woman, I needed to be escorted by a chaperone. The chaperone was known to them, as in both centres it was the social worker who worked with them.
- Anonymity: all names would be changed, and no permanent record would be kept of their attendance at the interview.
- What would happen after the interview: any information they gave would be used for research purposes. No transcripts would be seen by anyone other than the researcher and the translator.

The space where the interviews took place was a small consulting room, arranged with three chairs in a triangular shape. A small table was placed in the middle, on which the tape recorder was placed. At this point, I also asked permission to tape our interview. Participants were told that no permanent record would be kept of their voice on tape, and that transcripts would not mention their name, nor any distinguishing elements that could identify them (like, for example, mentioning place of birth). They were told that demographic information would also be stored under the same code name. They were also informed that once the transcripts had been made, the tape would be destroyed.

Three participants withdrew at this stage, as they did not feel

comfortable about the interview being taped. I engaged in a brief discussion with them about general issues, and did not exert any pressure on them to participate. A further four participants withdrew from the study in Riyadh. The reasons given for the withdrawal for the Riyadh participants were slightly different. All the reasons pertained to the fact that the researcher was female. One of the key issues revolved around participants not wanting to take part in the study for any other reason than to “flirt” with the researcher. One participant came to the interview simply to give a lecture to the researcher that what she was doing was not appropriate for a woman because she should not be engaging in a conversation of any kind with the opposite sex. He was extremely religious and once he has delivered his lecture he left the room and refused to be part of the study going forward. It is interesting to note that all four participants who withdrew from the Riyadh sample were Bedouins, a generally extremely religious group who stand by full segregation of the sexes and therefore found what the researcher was attempting as “wrong” or an “invitation”. According to Islam it is permissible for a woman to show her face, however one of the participants objected to the fact that the researcher had covered her hair but not her face, which is a good example of the difference between Islam and how it is currently translated into everyday life. The researcher had believed that by covering her face she would create too big a barrier for the interview to be useful; however, as it turned out in this instance, not covering her face made the interview impossible.

Given that the researcher was a woman, a chaperone was required at all times during the interviews as it is unacceptable for a female to be alone in a room with a male. Clearly, the chaperone therefore also needed to be a woman. The interviews may therefore have been terminated early because chaperones are often seen as informants. Secondly, the very fact that the male population was being interviewed by a woman is unusual and could have created some discomfort for the participants. During the preparation conversations with the chaperone it was agreed that when

given certain signals she would leave the room on a pretext, for example getting tea for the researcher and the participant. This meant that the researcher was still able to gather the type of information that was required for this study.

The core question that was asked of participants was: “Could you tell me why you started to use drugs?” It was thought that the question should be as broad as possible. Participants were allowed to give their accounts with minimal interference from the researcher, apart from the usual prompts. Open questioning was used here specifically, since no assumptions could be made about the types of answers and areas participants would draw on in constructing their accounts. Interviews were conducted in Arabic and translated by a certified translator. All names have been changed in order to protect anonymity.

Interviews were transcribed in full, and resulting data were analysed using thematic analyses (King, 1998). The research lens used for the analysis is described below. Emphasis was placed on understanding participants from their own perspective. No claims are made in this research regarding the ‘truthfulness’ of the accounts as presented by participants. Rather, it is by investigating the self-narratives that are offered as an explanation for the origins of drug use that ultimately greater insight and understanding of this phenomenon specifically located within a Saudi cultural context can be gained.

5.5. DESCRIPTION OF PARTICIPANTS

In this section, I have ensured that I give a background of the participants that is comprehensive, but at the same time does not include any information that might compromise their anonymity. All names have been changed to names that are in common usage in Saudi Arabia. When discussing occupations, I have made the categories broader. For instance, rather than specifying ‘army, air force, navy’, I use the term ‘military’.

All participants are from the generation that Yamani (2000) refers to as the ‘new generation’, i.e., the third generation since the inception of the Kingdom. The following six participants were interviewed in Jeddah.

Mohamed, 42 years old, is a former air steward, and is married with five children. He has been taking drugs for over 18 years, and this is the third time he has been admitted to the clinic for treatment. He initially used cannabis, but this escalated into the use of ecstasy and heroin, which he snorted and injected. He is the youngest of six siblings, and comes from a poor background. His father was an alcoholic and had been imprisoned several times. The father died when Mohamed was four years old. The consultant psychiatrist’s diagnostic formulation specifies that Mohamed’s lack of religious conscience and social deprivation are causal to his addiction.

Sami, 40 years old, used to be a goldsmith (now unemployed for several years), and is divorced with no children. He has been taking drugs for 11 years, and has been admitted to hospital for treatment six times. He uses heroin intravenously. He has seven full siblings and one half-brother from his father’s second marriage. He comes from a wealthy family, and started working in the family business after primary education. Shortly after joining the firm, his father died. The consultant psychiatrist’s diagnostic formulation states that the reasons for taking drugs are lack of religious conscience, lack of useful hobbies considering that fact that he is unemployed, and bad influences from his circle of friends.

Abdullah, 35, was formally a member of the military, and is divorced with two children. He has been taking drugs for 18 years, including cocaine, cannabis, crack cocaine, amphetamines and heroin. This is the first time he has been admitted to hospital for treatment. He is one of seven children, and moved from the family home to live with his grandmother at an early age. He describes his background as ‘not well educated but middle class’. Psychiatrist’s diagnostic formulation

mentions lack of religious conscience, peer pressure, and use of drugs for recreational purposes.

Samir, 42, is also ex-military, and is divorced with one son. He has been taking drugs for over 25 years, and has been admitted to hospital seven times for treatment. He uses cannabis, amphetamines and heroin. Samir is the eldest of five brothers, and comes from a wealthy family. His father used to smoke cannabis. The psychiatrist's notes state that he uses drugs due to lack of religious conscience, peer pressure, curiosity, lack of useful hobbies considering the fact that he was unemployed, and for recreational purposes.

Hassan, 41, ex-military, is single. He does not disclose how long he has been taking drugs, but states that he has been using heroin 'for a while'. At the time of interview, this was his seventh admission for treatment to the hospital. He mentioned using a 'variety of different drugs', and that included heroin. Hassan was raised away from his parents with his elderly grandparents, and describes his background as middle-class. Psychiatric diagnostic formulation states lack of religious conscience, peer pressure, prolonged leisure time, a family history of addiction, and recreational purposes.

Fahad, 38, ex-military, is single. He has been taking drugs for 10 years, and has been admitted to the hospital eight times for treatment. He uses cannabis and heroin. Of five brothers, he is the eldest. Naseem states that 'I was rejected as a child, and have not been favoured with my parents' love'. He comes from a professional class background. The consultant psychiatrist only states 'unknown reasons' as underlying his addiction.

The following six participants were recruited in Riyadh. Psychiatric diagnostic formulations were not made available in this clinic.

Turki, 32, used to be employed in the police, has now been unemployed for eight years, and is single. He has taken cannabis and heroin, and started using drugs when he was 14. He has been admitted four times for treatment. Turki is the third of six brothers, and everyone in his family used drugs. He mentioned he was bullied most of his life because of his small size.

Faisal, 44, used to work for an airline, and is married with three sons. Over the past 20 years, he has taken cannabis, amphetamines and heroin, and has been admitted for treatment eleven times. Of five brothers, he is the eldest. He describes his childhood as 'not extremely tough'. He is not readily forthcoming with information regarding his background and social status.

Sultan, 33, is ex-military and single. He has been taking cannabis, amphetamines and heroin for 17 years, and has been admitted to hospital sixteen times for treatment. Sultan does not offer further information.

Naif, 30, is ex-military, and is single. He has been taking cannabis and heroin for the past 16 years, and has been admitted to hospital six times. He is the youngest of seven brothers. Naif describes his upbringing as 'strict', and mentions that his father died when he was 14, which is also when he started taking drugs. Prior to his father's death, he describes his childhood as very happy with a strict father but one 'who was like a friend to me'. His family run their own trading company.

Bador, 41, ex-military, is married with five children. He has been using cannabis, amphetamines and heroin for 23 years, and has been admitted to hospital for treatment seven times. He is the youngest of six siblings. He started taking drugs after the death of his father. He states that he felt loved during his childhood by his parents and siblings. His family was mainly employed by the military.

Khalid, 33, is divorced. He never worked because he comes from a very wealthy family. He has been using cannabis and heroin for 17 years, and has had five hospital admissions. He is the second oldest of five brothers. He describes his family background as ‘very good – I got everything I asked for’.

Recurrent themes that emerge from these profiles are that by and large most participants have been admitted to hospital for treatment many times, there is a high occurrence of paternal death at an early age, and the main drugs used are cannabis and heroin. Many have a military background, which allowed them to travel abroad regularly. Participants come from a range of social strata. A further recurrent theme is the diagnostic formulation of ‘lack of religious conscience’.

5.6. CONSTRUCTING A LENS FOR DATA ANALYSIS

The key aim of this qualitative study was to explore how the constructs of alienation and assertiveness in addiction operate within a Saudi context. Since no research can ever be value-neutral and truly ‘objective’, it is important to position the research, and to make explicit the assumptions made by the researcher when interrogating the data.

The first step in analyzing the data focused on mapping the data according to a number of emergent themes. This is a valuable tool as the stories recounted reflect how the participants view their world and the key influences they perceive in their life. As Jarvilouma et al. (2003) point out, the text of a person’s life connects cultural and personal issues in a narrative of self. This type of analysis focuses on the lived experience or phenomena as they present themselves to the conscious. Practically, transcripts were read and words or sentences relating to the core phenomena under investigation (addiction, alienation, assertiveness) were extracted. This methodology follows the guidelines of descriptive analysis as suggested by Holloway and Wheeler (2000).

Following this, I have focused particularly on the interplay between different levels of analysis: cultural, social and interpersonal, and intra-personal. I investigate drug use in Saudi Arabia against the backdrop of a society in transition, where old versus new is a core theme in the production of a new identity, fit for contemporary living. I then investigate how the cultural level is internalised for the individual, drawing on the work of Standish (2003). I then broaden this out to investigate how the internal world intersects with the interpersonal and social. As stated previously in the original aims of the quantitative study, many research studies as well as government policies illustrate that drug users are alienated from society in terms of employment, family ties, etc. Drug user populations in the West (especially with heroin) are predominantly from deprived backgrounds, problematic upbringings, socially and economically disadvantaged. In Saudi Arabia, while less is known about the background, there is still a clear indication that drug users are alienated from the predominant mores of society. Both societies acknowledge that the reasons for this alienation are complex and not well understood (see, for instance for UK, the 2001 Drugscope Report, and for Saudi, the 2001 Iqbal article). The argument I propose here is that one aspect of this social alienation is through its interaction with self-alienation. Standish's work can offer an insight into the workings of being alienated from self, and also offer an insight into the link between being alienated from self and addiction. In particular, Standish's model shows that, apart from other underlying and contextual causes, the cycle of addiction both perpetuates and reinforces an alienation from self. This cycle illustrates, particularly in its final stage, why it is difficult to get the addict out of the cycle, as addiction prevents learning taking place. Since many approaches emphasise the learning of social skills (including assertiveness) as a core part of drug rehabilitation, it seems important to investigate the level of assertiveness present in substance users. The argument put forward by Schaler (2000) is also appropriate here, as it offers a critique of the dominant disease model by positing a free will hypothesis as an alternative explanation. If drug users

do indeed have a choice, then investigating the extent to which they have the ability to assert themselves against the drug use and 'say no' becomes an important aspect to investigate.

It should be noted that what is presented here are the accounts of drug users – it is their story, their insight, and their explanation. Understanding their world view, in combination with the theories described above, gives a rich insight into the phenomenologies of addiction, alienation and assertiveness. This is not a formal ethnographic study; nevertheless, there are some elements of ethnography that have been drawn on to present the data, the main one being the attempt to contextualise the study as much as possible. Practically in terms of coding the data, the methodology of Hoyle, Harris and Judd (2002) was used. Two coders examined the data in detail. Each coder was trained prior to the analysis to identify the core themes of interest to the present study. Example narratives were used to practice and to ensure similar judgments were being made. Each coder was asked to identify extracts where participants discussed addiction, alienation and assertiveness. These initial extracts were then pooled and discussed, and subsequently arranged under a series of themes. These are presented below.

5.7. ALIENATION AND ADDICTION

In this section, I will describe how alienation from Saudi mainstream society intersects with drug use in a variety of ways through an analysis of the participants' accounts in combination with the variety of theoretical lenses described. I will illustrate how a troubled childhood, linked in part to the shift between the traditional and the modern way of life, led to difficulties for these participants in attaining an identity. I will show how these subjects attained the identity of 'drug addict' in an attempt to cope with their identity problem. I will then describe how through a variety of trigger events, they have perpetuated this alienation and extended it into being alienated even further from self and society. While they use drugs in an attempt to heal their self-alienation, becoming

an addict results in further cycles of alienation.

5.7.1. Primary Alienation: From Self

As argued previously, alienation from self can be viewed as difficulties in locating an identity. Against the backdrop of a shifting Saudi identity, characterised by tensions between the traditional and the modern in Saudi society, it is difficult to tease out how what occurs on a societal level interplays with what happens at an inter- and intra- personal level. For instance, Yamani (2000) claims that one of the reasons Saudis hold on to the past is that it functions as a secure base for life, where rules for family and religion are so interwoven that they almost appear indivisible. While the new generation has not really experienced ‘the past’ (this is the first generation that has not got a direct connection to the way of life in the desert, where codes regarding conduct in terms of family and religion were established), it is clear that the past can function as a safe and secure notion in a confusing and morally ambiguous world: the rules are very clear, and what is good and what is bad are strongly delineated.

However, the sample of drug users here did not necessarily experience ‘the past’, in the form of an ideal base of family and religion, as safe and secure. There are recurrent themes of bereavement, of overbearing parents, of being isolated from the nuclear family, and of being picked on at school. Mohamed, for instance, recounts how “*my schoolmates despised and targeted me*”. The reason for this was that he was forced by his mother to sell sweets at school at an early age to supplement the family income, which had declined since the death of his father at age four. Sami recalls how “*my father’s death left a deep vacuum in me – I think if he were alive I would not have taken drugs*”. Abdullah states that “*my grandfather died when I was seven, so I had to live with my grandmother [...] I began to feel detached from my nuclear family*”. Hassan was excluded from school when his life destabilised after the death of his grandmother who had brought him up.

These various accounts show that the safe home life as associated with the traditional way of life may not have been as smooth for these participants. What can be observed here is that as modern ways of living become more prevalent, some of the secure aspects of the past diminished. Conversely, some aspects of traditional life may be experienced as less positive in a modern context. While 'in the past' living with a grandparent did not require leaving your own living space (as this was commonly shared amongst generations), nowadays families by and large do not share those extended living spaces. Thus in Abdullah's case, he was removed from what he refers to as his nuclear family. Selling sweets at school would not have arisen in previous generations, as school is also a modern structure. Arguably, access to drugs can also be regarded as an aspect of modernity, since although they may have been around for centuries, there was a self-regulatory structure in the past way of life (in the main through religion, and the societal observance of religious rules) that governed their usage.

To what extent these personal experiences of cultural deracination are different for this group than for their contemporaries is unclear, and they are unlikely to account solely for the use of drugs as a coping strategy. My argument here is not that drug use is an inevitability because of the difficulties that are inherent in the shift from traditional culture to modern culture, but that for all the participants in the sample, there were some major elements in their historical accounts that indicate a troubled childhood. This in turn may indicate difficulties in the attainment of a sense of identity, a sense of self. Nevertheless, it is also important to note that in the findings of the quantitative study, no significant differences were found between control groups and drug users regarding their formative experiences. For some in this current sample, however, there is evidence that formative and cultural experiences interact.

5.7.2. Thwarted Identities

The following excerpts will demonstrate how individuals struggled with attaining their own identities. In particular, they illustrate how, through their interactions with others, either family or peers, they became frustrated and resorted to drug taking as a way of addressing this frustration. Examples of these frustrated interactions include being rejected by others; not being allowed to marry; not being sufficiently mature to exercise self-determination. Some even claim that they were thwarted by the Devil, or a Zionist conspiracy.

Mohamed:

“I fell in love but both my mother and her family refused our marriage because of the hostile relations between the two families. I was very depressed because of this. Soon, I was on a trip and was in a low mood [...] and started taking drugs”.

Later he refers more to love relationships: *“the reason I took drugs was that I loved a girl but my mother deprived me of her company. My mother later made an engagement for me to a girl who was related to us. I felt she was like a sister to me, but I did not refuse the engagement for fear that my mother would get angry”.*

Also Turki:

“The woman I loved got engaged to someone else, but my father disapproved of the relationship. I couldn’t say no to my father”.

And Naif:

“Everything I did was a success, but my father refused to let me fulfil my ambitions [...] I cannot say no to my father”.

Many of the other participants described similar tensions between what

they wanted to do, and the choices they wanted to make, and the disagreement with some significant others. Others claim they were thwarted by more obscure ‘others’ such as the devil or a Zionist plot.

Fahad:

“I used to learn the Quran by heart and lead people during prayers at Ramadan. It was the Devil’s Eye. I remember once we were in Abha and after I recited the Quran I bled and when I started to recite the Quran my voice discontinued and broke”. It was after this experience that he turned to drugs. Being thwarted in his wish to be a ‘good’ Muslim, he believed it was the Devil who was responsible for turning him to drugs. For Mohamed, it was the Jews:

Mohamed:

“Gradually they taught me how to obtain drugs and seduce women. Believe me, that was a Zionist plan. Why only Saudi and Arab youth?”

As these quotes show, participants ascribe the onset of their drug habit to a variety of circumstances. The identity of ‘being a victim’ clearly comes to the fore here: participants report being victimised either by parents or family, the devil, or as part of a Zionist plot. In each of these cases, they feel they have to forsake something: being independent, grown-up, being ‘good’, being innocent – virtues that hitherto were important elements in the construction of their own identity. Being thwarted, they resorted to taking drugs, and in this way, achieved a different identity – that of a drug user.

5.7.2.1. Attaining The Identity Of Being An Addict

Drugs gave many of the participants the identity they sought to achieve. For some, it was identification with others: father; parental figures – wanting to grow up, ‘be big, and ‘be a man’.

For instance, Mohamed states that:

“My father died because he was an alcoholic. I recall seeing several times the bottle of drink and the glass he used to take his alcoholic drink. I also remember him in prison; since then I always remember how I saw my father behind the thick prison bars. When I grew up and become imprisoned, I felt that the place was familiar to me. That is because the scene of the prison bars [...] has never left my mind”.

Later in the interview, he adds:

“I think the reason I resorted to drugs was because of my father. I used to ask myself, is my father better than me? He used to drink alcohol ... I must be like him or even better and take drugs”.

For Turki, using drugs was all about wanting to be big:

“I used drugs when I was 14. Most of the people around me were using drugs. I wanted to be like them. My problem was that I was small in stature and I looked younger than my age. Everyone thought I was young- even at home they used to pick on me. In my neighbourhood they called me ‘the small one’. No one treated me according to my age, just my size. I had to do something to make them realise I was older, so I started using drugs. [...] I was left out of conversations in men’s surroundings, and they spoke to people younger than me but bigger in size. I used to feel that drugs made me bigger”.

Thus drug-taking, rather than drugs *per se*, became the magical solution for achieving the identity that was desired. A drug-induced euphoria is merely a transient subjective state, whereas drug-taking is an act of defiance. It is demonstrably risky, illegal, transgressive, anti-authoritarian and anti-Islamic tradition. It is also interesting to note that most of the participants came into contact with drugs while travelling abroad. Yamani (2000) pointed out that the opportunity to travel was one of the key ingredients that was causal to the Saudi identity conflict.

Through travel, she argues, the new generation of Saudis experience cultures and mores unfamiliar to their own, which make them reflect on aspects of their culture and way of life which they previously accepted without questioning. So drug-taking is a thoroughly modern response to feelings of alienation and lack of identity, a clear way of rejecting the past and becoming what you think you want to be.

5.7.3. Conclusion

I have shown here that the participants I interviewed came from a childhood that was not experienced as secure and safe. This in itself may not be unlike the experience of other, non drug-using Saudis. Yet against this backdrop of societal change, characterised by tension between tradition and modernity, these participants struggled with attaining their own identity and experiencing a coherent sense of self. They reported being thwarted by some 'other' – be it a father, the Devil or a Zionist plot. Their response was to become addicted, as this either offered a solution ('becoming big', or becoming like the alcoholic father by whom they felt thwarted) or obliteration (focusing completely on the cycle of addiction, which was to become a sufficient identity). Travel abroad, for many presenting the first opportunity to take drugs, also precipitated the collision of the new, modern or different collision with the traditional mores of Saudi life.

5.7.4. Secondary Alienation As A Result Of Drug Use

All the above accounts describe both the background and the immediate motivating events that participants claim led them to use drugs for the first time. Under Standish's model, these could all be viewed as trigger events. Once drugs were identified as a way of coping with complex issues relating to identity and alienation from self, participants describe how, through the addictive cycle they progressively became further alienated from themselves, families and society.

5.7.4.1. Stage One: Trigger Events

Standish (2003) classified trigger events into four different categories: biological, social, emotional and behavioural. Most of the accounts given by participants above could be included in one of these categories. While arguably all events have emotional components, many of the above accounts illustrate the difficult emotional experiences that participants view as causal to their drug use: death of a father; rivalry with a father; defiance of authority; need to feel higher 'status'; experience of lack of love by parents. Most participants describe experiencing social pressures, such as peer pressure; being in an environment where everyone else takes drugs (for instance, in new working environment – shop; airline); separation from parents; pressure to achieve; thwarted ambitions due to parental decision making; and work pressure.

Furthermore, different behaviours are required when outside traditional Saudi culture. Thus some reported a feeling that one needs to be more active.

Again, I want to point out here that the data I present does not assume that these participants are in any way different from the general population. However, all these triggers lead to an emotional response in the addict that he cannot handle. The trigger events and pressures lead to a strong affective reaction that cannot be adequately verbalised. The affect is somatised, because it is so overwhelming and uncomfortable. As a result, there is a lowering of self worth and self-esteem, which in turn leads to a craving signal to 'repair' esteem and worth. Since it is interpreted as a somatic signal, a somatic response is required – for the addict, drugs (Standish, 2003).

5.7.4.2. Stage Two: Using Drugs, Followed By A Reduction In Tension

It is in this stage that Standish elaborates on drugs as the magic

solution, and the answer to the woes experienced in the trigger phase. A complex compromise solution is achieved. However, through repeatedly resorting to drugs to achieve solutions, the addict becomes less and less able to resolve internal and external world problems in the long run. Evidence for these two aspects is presented below.

Sami reports that his work improved following the use of drugs:

“I tried drugs and I liked it - It helped my drawing”.

And:

“I started work, and whoever saw the piece of work that I did while under the influence of drugs said it was the most beautiful they had ever seen. I continued taking drugs in order to concentrate better on my work”.

Turki also experienced it as a solution to his problem (being small):

“I used to feel that drugs made me bigger”.

And Naif:

“[Drug-taking] made me feel less lonely, as I had no friends – it gave me closeness to my brother who was also a user”.

Fahad reported:

“Drugs move me away from being depressed”.

Mohamed:

“I fell in love with my cousin but my mother and her parents refused our marriage [...] I was in a low mood, I was talking to a colleague on a trip who said he had something that would make me forget all my miseries. I fell asleep for ten minutes during which time I felt like flying in the air

and very happy. I took more of the stuff as it worked”.

Abdullah:

“Taking drugs made me feel active and confident [...]. I started drugs to escape my problems”.

5.7.4.3. Stage Three: The Withdrawal Stage

This is when it becomes obvious to the user that they are being deprived of something, yet despite realising that it may not be the best solution to continue, they continue or resume doing it anyway.

Abdullah again: *“I fell in love with a woman, but when I proposed to her, her brother refused. I went back to taking drugs”.*

Samir:

“When I stopped taking drugs I felt a vacuum”.

Initially no problems were reported, but contact with family became less frequent. There is some evidence of shame and guilt, which in turn leads to continued use. In the transcripts, there is not a lot of evidence for this third stage. In part, this may be because the interview’s methodology may not be sophisticated enough to gain information about this part. In future, more specific questions regarding tolerance, withdrawal and resumption of drug taking could be asked. There were, however, many reports on the further, wider alienation that resulted from the continued addiction. As Hassan’s example shows, alienation not only from self but from peers and society became an extra burden:

“People, neighbours and my family hated me after I became addicted; I became an undesirable person among people around me”.

Fahad mentions:

"I used to blackmail my siblings and treat my mother harshly, and gradually lost contact".

Sami also states:

"I did not see my father before his death. My mother said that I was the cause of my father's death because he was grieving for the condition I had reached".

5.7.5. Conclusions

It is clear from this evidence that Standish's (2003) model has some merit. Following an initial series of trigger events, users adopt drugs as a way of gaining some coherent identity (the craved for solution), yet at the same time get caught in a different cycle, which ultimately results in further alienation. They may have solved their internal problems for a while, but new external ones are created, reinforcing the lack of an effective solution to the former.

5.8. ASSERTIVENESS AND ADDICTION

In several of the quotes above, there is already evidence of drug taking as an assertive act. In this section I want to explore in more detail the various ways in which the concept of assertiveness can be approached in the context of addiction.

Depending on what explanatory model is used, taking drugs can be linked in opposite ways to assertiveness. Lack of assertion would accord with the 'disease' model; self-assertion would fit in with the 'choice' model. What I mean by this is that if addiction is conceptualised as a disease, then the argument goes that it is important to assert 'one's self'³ against the disease of using and continuing to use. I would argue, however, that the very act of taking drugs, is a way of asserting oneself in

³ "One's self" is used here in the sense of "*Nafsi Mutma`inna*", the Contented, Fulfilled and Satisfied Self

order to create and produce an identity. Lack of a firm sense of identity, alienation from self, is countered by taking drugs – even though this may only be a temporary solution, and a potentially (self) destructive one at that.

In the quotes presented above, it can be clearly seen that participants' drug use has many functions, overriding one being to increase the ability to cope with the situation they find themselves in. Participants report reduced anxieties, having better sex and work, being bigger. It is only when the negative effects of the drugs start taking their toll that others (usually close family members) force them to respond to the secondary problem (addiction) by seeking treatment for their addiction. In the treatment centre, the first challenge they encounter is once again to 'give up' self by 'giving themselves' to Allah, and allowing Him to guide them. Arguably, this was the very deficit they sought to 'cure' (i.e., obliterate) with drugs, in the first place and therefore treatment could potentially act as a further means of self-alienation.

5.9. CONCLUSIONS

The interviews provide rich vignettes revealing how a sample of Saudi men commenced and experienced drug use, and for what reasons. In the context of shifting identity in Saudi culture, I have presented an account (drawing on Standish's 2003 work) of how these participants struggled with identity issues and sought to 'cure' themselves (i.e., their 'selves') by becoming addicts, thus asserting themselves against the dread of self-alienation and lack of identity. I summarise some further key themes below.

5.9.1. Removal Of Support Structures

The loss or absence of a firm support structure, be it the father, prospective marriage, indigenous culture or religion, forms one of the most common themes in these participants' accounts. Some examples quoted are listed below:

- The death of the father or significant other
- Moving abroad, away from the family
- Significant family members moving abroad
- Overly permissive upbringing with lack of supervision
- Overly strict upbringing, experienced as oppression instead of support
- Betrayal by family members (failure to acknowledge or support wishes and aspirations, such as forbidding marriages, making one member work on behalf of the rest of the family)

5.9.2. Thwarted Ambitions Or Desires

Another common theme which emerges is the notion of being hindered in the achievement or fulfilment of desirable goals. These include:

- Denial of love: for instance, by not being able to secure parental permission for marriage
- The pursuit of educational goals: for instance, having to forego education for economic reasons
- Career aspirations: for instance, when parental approval for chosen career paths is not given

5.9.3. Beneficial Effects

In all cases, initial beneficial effects are perceived, enhancing the feeling that taking drugs is an appropriate way of dealing with the trigger situation. These effects include:

- A more satisfying sexual experience (except with heroin which suppresses libido)
- Greater concentration and improved quality of work (during the effects of amphetamines)
- Succeeding in filling a void
- Creating a new identity

I want to note again that loss of support structures and thwarted ambitions may not apply exclusively to addicts, and might occur equally often in non-addicts. In this sample, it was clear from the data that the removal or absence of social support (mainly family support) was cited most often as a reason for drug addiction. It can be argued that such an absence of support systems makes one vulnerable and places serious constraints on coping strategies which would otherwise be called into play when facing difficult life events. Invariably, participants specifically encountered such problematic experiences in childhood or adolescence which they felt incapable of dealing with. The lack of family support, and in some cases the direct involvement of the family in creating those problems, denied these participants access to social support structures which under any normal circumstances would be called upon to help a young adolescent overcome difficulties. As the coping literature has demonstrated, social support from adults and peers is extremely important when direct, active, self-reliant problem-solving is unsuccessful. In such situations, the adolescent or individual is likely to employ more passive or avoidant strategies. According to certain classifications of coping strategies, self-destructive reactions, such as substance abuse or engaging in dangerous behaviour, form part of these passive avoidant strategies, which have on the whole been shown to be less conducive to satisfactory problem resolution. From one perspective, however, drug-taking in men is the opposite of passive and avoidant – it is defiant and self-affirming.

The participants met severe restraints and faced opposition to the fulfilment of their important life goals, such as marriage and career, which are crucial during adolescence. These thwarted ambitions were partially caused or perpetuated by their family situation. In any case, the family failed completely in helping to find a solution to these problems.

This combination of lack of social support and thwarted ambitions leads to a threat to self and social identity. With all the traditional active

problem-solving strategies being incapacitated as described above, the individual is alienated from himself and his goals. Cultural norms prevent the exertion of assertive coping strategies and the use of drugs or mind-altering substances becomes an attractive option as a strategy for coping with these feelings of alienation. The picture presented here of the causes of drug use fits the description of one of Wurmser's (1974) types of drug user: the compulsive user (*cf*:41) - i.e., the individual who becomes addicted to avoid the distress of depression, anger, rage and anxiety.

Once these conditions are in place, if and when drugs become available the individual experiments with them and ultimately develops an addiction. The generally limited access to drugs in the Kingdom of Saudi makes the issue of availability a key concern. In some cases, participants were introduced to milder drugs such as cannabis and alcohol by work colleagues, friends or family members but more importantly, access to harder drugs happened when they travelled abroad and experienced foreign cultures. These trips were mostly related to work and, significantly, most of the participants in our sample were employed in either a military or aviation setting, thus having easier access to drugs due to the amount of travel involved in their jobs.

Participants generally stated that they had shown an initial reluctance or resistance to substance use on the basis that this did not fit with their own self concept: for instance, on religious grounds amongst others- wanting to be a 'good Muslim'. However, they succumbed to peer pressure and to the norms of the new cultures they became acquainted with. In many cases, the initial providers of the drugs were equally reluctant to provide drugs, pointing out the illegality and negative effects involved.

However, the lack of fit of the notion of being a drug user into the self-identity was overcome in many cases by identification with a

significant other (for instance, the father), or in other cases a new social identity was created by seeking the company of peers who were using substances. This represented just one of the initial beneficial effects experienced. Others included enhancement of sexual experience and heightened productivity. Overall, however, drug use was experienced as filling the void left by the loss of social support structures and thwarted ambitions. In the short term, drugs were experienced as an effective way of coping.

A period of escalation and increased addiction followed, as the strength or nature of the drug ceased to be sufficient in achieving the desired goal of coping with the loss of structure and the pain of thwarted ambitions. Their increased use ultimately perpetuated the sense of alienation (including social exclusion and withdrawal from society) and further rejection by family. Participants on many occasions attempted to stop by themselves, but were thrown back into substance use to avoid withdrawal symptoms.

CHAPTER SIX: DISCUSSION

6.1. INTRODUCTION

Using a variety of levels of analysis, I have provided evidence that the struggle for a core self-identity lies at the heart of the stories recounted by the participants. Against a backdrop of cultural identity shifts between traditional and modern influences, these participants seek to cure a thwarted sense of self through the use of drugs. While in the long term this proves counterproductive, it nevertheless achieves the aim of asserting an individual, modern identity. Indeed, I have demonstrated that the axis of traditional-modern is an important parameter when investigating notions of alienation and assertiveness in the addicted person in a Saudi context, particularly when alienation is viewed as ‘difficulty locating an identity’. Most of the participants could be viewed as ‘third generation Saudis’ – their grandparents were living at the time of the unification of Saudi Arabia, their parents when the oil economy heralded an era of affluence and the establishment of political infrastructures. They themselves were children at the time of the 1984 economic down-turn, which for the first time saw economic insecurity affecting the Kingdom. Furthermore, they were the first generation who did not have a direct connection with the desert way of life, where codes regarding conduct in terms of family and religion were established. The past serves for many as a secure base for life in a confusing and morally ambiguous world (Yamani, 2000): the rules for family and religion are so interwoven that they appear as the same. While this is experienced by everyone, the participants in my sample sought recourse to drugs as an attempt to solve difficulties. This cultural level of analysis is key to an understanding of addiction in Saudi Arabia.

How do these results look when considered in the context of alienation? As discussed in previous chapters, there is doubt regarding

whether or not the concept of alienation has validity in a Middle Eastern context. Probably, this is because of the way it has been measured, using items derived from Western ideas and samples. However, when we investigate the concept of alienation through the accounts of the participants, some signs of alienation are apparent. If we turn back to Seeman's (1959) categorisation system we can see that the six elements are clearly in evidence here. Through the use of drugs, participants were definitely trying to give meaning in their situation which had become 'normless' through the lack of social support structures. As Seeman (1959) points out, alienation will occur when norms lose their regulative force. Participants equally felt powerless to organise their own future, and through escalated drug use became progressively isolated, and thus even more alienated. Horney (1950) is also relevant here. I suggested that it is the removal of social support and thwarted ambitions that led to a threat to self-identity and social identity. In Horney's terms, this threat to self would be seen as self-alienation, as it is a threat that functions to thwart the original force towards individual growth and fulfilment through which individuals may achieve full identification. Some points however can be disputed. For instance, Erikson (1968) cites rebellion against the family as a major factor contributing to the alienation of young people and their use of drugs. Our findings suggest that it is not rebellion, but quite the contrary: loss of support from the family pushes these participants into drug use. Wurmser (1974), who explicitly linked drug use and alienation, clearly identified the role of a threat to self. He points to the family relationship pattern in which parents fail to provide positive support during developmental crises, with a lack of trust developing as a result of these inconsistencies. He elaborates that there might be a specific element in the psychopathology that will interact with this lack of support. This might then be exacerbated by an acute crisis, leading to the desire to escape from the internal distress experienced. A third element he cites as linking alienation and drug use is the conflict of values between the individual and his or her social environment. In addition, the seductiveness of the peer group and the availability of drugs

to relieve the unbearable inner turmoil encourage the user to make the drug the primary source of escape. Drug use, then, is identified by Wurmser as an attempt at self-treatment for the overwhelming effects of loneliness, rage and shame - in other words, to compensate for the overwhelming feelings of being alienated. The model developed by Standish (2003) proved useful in understanding alienation and assertiveness, and this study provides some empirical evidence to support the concept.

In the chapter on assertiveness, we argued that assertiveness might be an appropriate coping strategy to prevent the sense of alienation associated with addiction. It is here that cultural differences are perhaps at their most important. In retrospect, as with alienation, the concept of assertiveness could also be viewed as a distinctly Western construct. Throughout the literature, assertiveness is always viewed as a positive quality that is almost essential if one wants to protect one's sense of self and one's differentiation from other and individuation towards self. In a Middle-Eastern culture, where the dominant paradigm of the family reigns supreme over the cult of the individual, assertiveness is almost invariably frowned upon and discouraged. Under Islamic law, parents must be obeyed almost as unquestioningly as Allah. We could therefore argue that individuals will almost inevitably have an external locus of control. However, while Rotter's (1972) theory looks at locus of control in terms of beliefs that are held by individuals, it should not be forgotten that, for lay people in the Middle-East, these are not merely psychological constructs but are actually firmly grounded in the reality of their day-to-day experiences. In the quantitative study, it was found that the Saudi sample was significantly lower in measures of assertiveness than the UK sample, with no significant differences between Saudi drug users and control groups. This further indicates the cultural presence of an external locus of control.

6.2. CONDUCTING THE STUDIES

In retrospect, it may have been more useful to conduct the qualitative phase of the research prior to the questionnaire-based one. However, important lessons have been learned from this. It has been clearly demonstrated that a body of knowledge developed in one context cannot be translated to different cultural contexts unproblematically. This research highlighted the sometimes artificial nature of data procured by measurement instruments. At the same time, it has demonstrated the usefulness of a semi-ethnographic and qualitative approach to complex phenomena such as substance use.

This thesis has demonstrated various points that are important both methodologically and conceptually. Conducting research comparing different cultures is fraught with difficulties. Not only can it not be assumed that measurement instruments will be valid across cultures, but also different societal attitudes towards undertaking research (particularly in a sensitive area such as substance abuse) can be problematic in terms of access and willingness of participants to cooperate in the research process.

We have demonstrated here that while initially level of alienation and assertiveness, combined with social background, could not be linked to drug use in both UK and Saudi sample, the subsequent qualitative analysis showed that these concepts do indeed have currency across the two cultures investigated. As these claims are based on findings derived from a small sample of interviews, however, further research is needed to develop items from these interviews, in order to compile an instrument that is ecologically sound for a Saudi population. This might enable the initial hypotheses suggested in this thesis to be re-tested, and could lead to more solid, generalisable claims regarding the roles of alienation and assertiveness in the aetiology of drug addiction.

6.3. IMPLICATIONS FOR THEORY AND PRACTICE

In principle, the main philosophy, derived from Islam, that underpins the use of alcohol in Saudi Arabia, should be transferable to the use of heroin. Indeed, under Islamic law, ecological factors and pre-legacy of a step-by-step system of gradual desensitisation, persuasion and effective community involvement was applied for fourteen centuries. To date that system is keeping most of the Middle East 'dry'. It is therefore somewhat surprising that current treatment of heroin addicts does not particularly focus on either the ecological factors or the involvement of the community. Perhaps through the rise of a more fundamentalist interpretation of the religion, the main focus has been on re-implementing religious beliefs when dealing with drug addicts. As can be seen from the description of the diagnostic formulations by the consultant psychiatrists in our qualitative sample, apart from 'unknown reasons', the main cause of drug addiction was cited as 'lack of religious conscience'. I would argue that reintroducing the concept of community involvement, and perhaps specifically family involvement, could lead to more effective treatments that will prevent the large number of readmissions experienced by our sample. Qureshi *et al.* (2000), who examined drug use patterns in psychiatric populations in Saudi Arabia, concluded that parents can play a key role in drug prevention through controlling the money supplied to children. This research would radically oppose the reduction of the family influence to the mere consideration of funding. From the sample used here, it is clear that the family, as the locus of support, structure and decision-making, should play an integral role in devising different strategies for coping with the emotional disturbances, which lead to alienation of the individual. Reliance on this positive resource would remove the need for the individual to rely on the negative resource of drugs.

By using Standish's (2003) model, we have also gained insight into drugs as coping strategy. There are three basic models of coping functions in substance use. A model of direct affect regulation claims

that substances produce change in affective states. For example, they reduce anxiety (Cappell and Greeley, 1987). Other versions posit that substance use has a function in reducing negative affect and increasing positive affect. An alternative view is that substance abuse assists coping by providing distractions from problems: for example, diverting attention temporarily from unpleasant self-awareness (Steel and Joseph, 1990). Thirdly, substance use may provide performance enhancement: for example, tobacco may improve performance because of attentional focusing and enhancement of a well-learned response (Grobe *et al.*, 1991). Ashby *et al.* (1996) point out that coping functions may vary considerably amongst individuals, depending on initial exposure to the substance and subsequent use in different situations. All three functions are evident in our qualitative data.

Lazarus and Folkman's (1984) transactional model predicts that problem-focused coping reduces the level of problems that could create stress, and is thus protective with respect to substance use. Emotion-focused coping does so as well because it reduces the level of internal emotional distress. For our participants, both of these were largely unavailable. For instance, their ambitions were thwarted (problem-solving); in most cases emotional support was unavailable, as it is not part of the culture; those who could provide it had often died, or perhaps participants mistrusted their family. A model of coping therefore needs to be devised that both addresses problem-focused and emotion-focused coping functions, and is at the same time sensitive to the Middle Eastern context. Basically, it is proposed that by providing new, (or improving existent) coping strategies, the individual is better equipped to deal with the problems of self-identity and social identity which he encounters.

In a paper by Ayers *et al.* (1996), a comprehensive taxonomy of coping styles is presented. From this, we can make the following relevant observations to further understand what a treatment programme should include. Its aim would be to improve existing styles, and provide

more adaptive strategies. In this respect, reference to the role of the family would be regarded as crucial. At present, the coping solution that substance use provides addresses the need for affect regulation, problem solving and performance enhancement. However, this is only temporary and ultimately unsuccessful. Arguably, substance use is a way of coping with the effect of not being able to cope with life situations in other more direct and constructive, problem solving- ways. A treatment programme focused on boosting and developing other more effective coping strategies could in theory make the need for drug use as a coping strategy obsolete. What other coping strategies could be available? Ayers *et al.* (1996) distinguish between five higher order dimensions of coping. These are:

- Problem-focused strategies
- Direct emotion-focused strategies
- Distraction strategies
- Avoidance strategies
- Support seeking strategies

Problem-focused strategies reflect cognitive and behavioural efforts to manage or change problems that cause distress. Previous research has shown that children's' problem solving is negatively correlated to mental health and substance use, and positively correlated with self-efficacy (Wills, 1986). The participants in our sample were all thwarted in this style of coping (e.g. in their marriage and career aspirations) largely because of lack of support from the family. A treatment involving the family as a cultural institution would focus on increasing the understanding and respect for the individual's wishes. In a sense, if family is so culturally important, this importance needs to be awarded to all members. Assertiveness in the traditional Western sense cannot be easily applied in this context, because of the hierarchical family structure in Saudi Arabia. However, by involving the family from the start of treatment and throughout, positioning the substance user as 'in need of

family support' rather than as a source of shame, the development of shared family-based effective problem-focused strategies would be facilitated.

Direct emotion-focused strategies involve seeking understanding of the situation; i.e., cognitive efforts to find meaning in a stressful situation and to understand it better. Although, these strategies do not seek to put a positive interpretation on the situation, they involve positive cognitive restructuring: i.e., thinking about the situation in a more constructive way, accepting that one can live with the situation the way it is. They also involve expressing feelings, either by an action, a verbal expression or simply an overt release of emotion. This is a solitary activity, and does not involve discussing feelings with other people. However, in the case of people already alienated from themselves, this coping style may not be sufficient or readily taken on board. Arguably, it is a way of coping that already requires a high degree of emotional maturity.

The distraction coping strategies are characterised by physical release of emotions and distracting actions. The individual uses some other activity or stimulus to distract her or himself from dealing with or thinking about the problem situation. This strategy is akin to the functions of drugs in reducing negative affect and increasing positive affect by diverting attention temporarily from unpleasant self awareness as described by Steele and Joseph (1990), this being one of the main function of substance use. Any treatment should attempt to avoid the use of this type of coping strategy.

The fourth style of coping, the avoidance strategies, involves using avoidant actions and cognitive avoidance. Avoidance strategies allow the individual to manage emotion by stopping thinking about the problem entirely. Avoidant actions include behavioural efforts to avoid the stressful situation by staying away from it. Cognitive avoidance involves efforts to stop thinking about the problem, using fantasy or wishful

thinking. Arguably, drug use falls under this sort of passive coping response also, and should equally be avoided.

I would maintain that the greatest improvement in the development of more effective coping strategies for an individual at risk of becoming a drug user would result from a focus on support seeking strategies. These strategies comprise problem-focused and emotion-focused support dimensions. More precisely, they involve the use of other people as resources to assist in seeking solutions to the problem situation: i.e., as sources of advice, information, or direct task assistance. They also involve the use of other people in listening to feelings or providing understanding to help the person to be less upset.

What I am advocating here, then, is the introduction of a system of coping that is family rather than individual based. While this may not sound radical to Western ears, in the Kingdom of Saudi Arabia this would signal a seismic shift in the way drug users are viewed within both culture and family. Yet, it is arguably not unachievable in the same way that increasing assertiveness might be. Since lack of assertiveness is an issue of the culture rather than the substance-using sub-culture, too much of a structural change would be required. However, maintaining the central position of the family, shifting its main role from controlling to enhancing the experience of family for all family members, would not 'attack' the very fabric of the notion of family in the way the notion of asserting one's self against it would. Further developments from the work presented in this thesis should include a critical assessment of the Western literature on this topic, resisting the temptation to introduce a Western model immediately into a Middle Eastern context.

However, many obstacles may stand in the way, not in the least those pertaining to cultural identity. As mentioned above, in a time of shifting identities and cultural changes between the old and the new, the discipline of social science is not immune to these influences. In some

ways, there is almost a 'science as competing religion' argument. While the disease model has a lot of currency because of its scientific status, it could be argued that it is incompatible with religious therapy. In Saudi Arabia, it is not the same line as groups such as AA take, in that power needs to be given to a higher entity to seek strength to cope with the disease. Rather, it is the person who sought to take drugs who is responsible, because of a lack of religious consciousness. This is a subtle but important distinction. In some ways, religious therapy holds that using drugs is a choice, in line with the theory espoused by Schaler (2000). As such, it could actually be more liberal and appropriate than the disease theory doctrine.

6.4. LIMITATIONS OF THE TWO STUDIES

It is important to draw attention to some methodological limitations of the studies conducted in this thesis. In particular, I want to expand on the cross-cultural validity issues regarding measurement, and the validity issues regarding the qualitative investigation.

In hindsight, several issues have been ignored in the quantitative study. These concern translation, scaling assumptions, and validation. Translation is the least problematic of these issues, since clear guidelines were followed, but do nevertheless have some limitations. Two native speaking licensed translators independently translated the instruments from English into Arabic. Two further translators re-translated them from Arabic back into English. However, there was probably not enough emphasis on conceptual translation – all translations were very exact and literally equivalent, hence providing some of the ensuing problems. While these translations were piloted to evaluate acceptability and understanding of the translation, no significant comments regarding changes were reported. This may have been due to compliance of the pilot group, however – participants may have been reticent to make what they would consider critical comments, as this is not part of the prevailing Arabic culture from which they were drawn. This possibly led to some

more serious limitations regarding scaling assumptions. While Cronbach's alpha indicated that the scales were reliable for the translated scales, this is an insufficient justification for their use. Examination of the validity and comparability of the scales is necessary for their proper interpretation. Conducting test-retest would have helped in this respect, but was not carried out. In terms of validity, studies of validity increase understanding of the meaning of a score and the meaning of changes or differences in that score. This is usually done by examining content, construct and criterion validity. Factor analysis usually provides a good indication of the construct validity of an instrument, and the factor analysis conducted in this study replicates previous factor structures to a certain extent. However, because the data do not fulfil the necessary requirements to be considered parametric data (in particular because there is no homogeneity of variance), factor structures cannot be considered as robust. Since no other Arabic measures of alienation and assertiveness were in existence at the time of the study, it was also impossible to conduct criterion validation studies. The most important conclusion to be drawn from these methodological and statistical limitations is that it cannot be argued that like with like has been measured. This flaw has likely influenced the results, hence these need to be treated with caution. More time should have been spent piloting the measures with an Arabic population at the translation, scaling and validity stages. It cannot be assumed that a single structure or concept will be replicated across cultures unproblematically. (indeed, we know they can not-e.g.)

In an attempt to remedy this, the qualitative study was undertaken. I was new to conducting qualitative research, hence some limitations to this work also need to be explored. I want to draw attention to limitations in the recruitment of participants, conducting the interview, and analysing the data.

Participant recruitment was a difficult task, principally because most users are male and I am a female researcher. This meant that I

needed a chaperone at all times. The presence of this person inevitably made the interview situation less intimate, and participants may have edited their responses quite heavily. It is also likely that the people in charge of recruiting the participants may have pre-screened them prior to the interview, so I only saw 'compliant' interviewees who would follow a general 'hospital line', and would restrict the amount of information they divulged. I already mentioned that several participants withdrew from the study because they considered it to be inappropriate to be interviewed by a woman. This bias may have been present to a lesser extent in participants who did consent to be interviewed. It would have been interesting to have similar interviews conducted by a male researcher and to ascertain whether and how responses may have differed. A further limitation concerns the accusation of 'finding what you want to find' in qualitative studies. It is true that only parts of the data transcripts are presented here. Interviews yield a vast amount of data, and selecting extracts is inevitably subjective. I addressed this subjectivity in two ways. Firstly, by using a second coder, some intersubjectivity could be established – we usually were in agreement that the extracts presented were indeed representative of a general theme. Secondly, I acknowledge that qualitative data analysis will never be wholly objective, and have tried to work with the subjectivity by being reflexive. For instance, by acknowledging my role as a co-constructor of these narratives, by reflecting on my position as a woman in the interviewing context, and by reflecting on societal and contextual issues more general.

6.5. CONCLUSIONS

I have demonstrated in this research that the concepts of alienation and assertiveness are to a certain extent useful perspectives from which to view addiction in both Western and Middle Eastern cultures. However, it could be argued that viewing all three of these constructs (alienation, assertiveness and addiction) unproblematically is at best culturally and contextually insensitive, and at worst fundamentally flawed. In this final section, I will draw on the work of Littlewood (1998), Littlewood and

Lipsedge (1997) and Kareem and Littlewood (2000), beyond doubt the seminal works on intercultural research with regard to psychiatry. As Littlewood and Lipsedge (1997) ask, who is the alien and who is the alienist?

As a woman, a Muslim, a Saudi and a social sciences researcher, I inevitably have a range of inherent belief structures that guide my investigations and my views of the world. Social science research, with its predominantly Western roots, at times conflicts with the traditional belief and value structures of my society. As a woman, my experience of Saudi culture is different from that of the male participants I studied. The constructs I chose to investigate are based on a framework that has a different origin than the society I come from, and indeed the one I sought to research. According to Durkheim (in Littlewood, 1998), the symbols by which we think are reflections not of individual experience, but of the social order. Applying this here, 'social order' can refer both to the culture of the land and the culture of social sciences research. We have, then, a clash of central belief systems, each of which seeks to inculcate and make compulsory pivotal concepts such as moral and cognitive ones. In other words, taking the individual as the level of analysis, and assuming that all psychological research can transcend social boundaries, is bound to lead to erroneous conclusions. As Littlewood (1998) argues, a truly transcultural psychiatry (or psychology) is concerned not only with aetiology and epidemiology, but with meaning. This implies that what is seen in the West as real illness and in other cultures as 'variation or confusion' ceases to present a sound argument. Instead, cultural context should take centre stage, and the process by which something becomes 'normal' or 'abnormal' is seen as the product of social and political processes within a culture. For instance, Littlewood and Lipsedge (1997) point out that 'culture' in the West is only introduced when the patient is not white. Western psychopathology is usually perceived, by mental health professionals, as if beliefs about illness, accepted patterns of expressing distress and childrearing patterns were

irrelevant to the patient when they are white – but not if they are black. Littlewood and Lipsedge (1997) focus clearly on the interpretations and meaning systems that are applied from a Western body of knowledge to ‘others’ as deviations – not as different. It holds, then, that my applications of Western constructs such as addiction, alienation and assertiveness are erroneously ‘seeing’ these constructs as similar in Middle Eastern societies, whereas in fact the product of the views through these lenses may actually mean something totally different.

Once freed from the notion that psychopathology can be applied unproblematically in different cultures, a number of different observations can be made. As Littlewood (1998) points out in a paper entitled “The Imitation of Madness”, what is considered aberrant behaviour is by and large defined by the cultural context. He cites examples such as a woman who feels she has an atomic bomb inside her, versus governments who are ready to deploy such weapons – which one is more mad than the other? If people are ready to accept a policy, then that policy becomes mainstream. If we apply this to drug use, in the West there has been a growing trend to accept cannabis use. Once marginalised and seen as ‘bad’, there are now moves to advocate its beneficial effects on those suffering certain illnesses. Even policing of cannabis use has been more relaxed, with the police often turning a blind eye to personal users (as opposed to dealers). This example illustrates two elements central to my following arguments: what is deemed to be ‘bad’ is not fixed but contextually defined; permissiveness and ‘freedom of choice’ arguments are important and persuasive in Western cultures. As to the former, cannabis use in Middle Eastern culture is officially regarded as ‘bad’, but partaken of by an arguably sizeable section of the population. Again, it is difficult not to generalise here. ‘Middle Eastern’ is not a homogeneous category – differences between Lebanon and Saudi Arabia, for instance, are substantial in terms of values allocated to drug use. It is ‘permissiveness’ that is central here – some countries are more willing to allow or at least tolerate expressions of permissiveness within

the culture, whereas others ban them completely, so any expression of permissiveness or 'freedom of choice' has to be experienced in a different culture, with the symbols associated with that culture.

As to the latter, drug use forms part of the construct of a 'free society' for Middle Eastern cultures. Particularly with the increasing rise in fundamentalism, permissiveness is regarded as a 'Western illness' that should be avoided. Not everyone in the Middle East is fundamentalist, however. To argue that people are 'alienated' from their original culture because they do not necessarily subscribe to its mores inevitably becomes a value-laden (and pejorative) judgment. I would therefore argue here that it is the use of drugs that allows Saudi addicts to express a 'freedom of choice' rather than 'being alienated'. I offer this view as an additional narrative - it does not seek to invalidate my previous arguments in the preceding chapters, but it provides a different lens through which to view them from a transcultural perspective. From a dialectic position, then, drug use can mean both alienation and assertion of identity. Neither of these positions as such implies an inherent value (good or bad) – rather, it is the gaze of the observer, which constructs these values.

A similar argument can be made with regard to assertiveness. Hitherto, I have viewed assertiveness mainly from the position that 'if people were more assertive, they would be able to cope with pressure and say no to drugs'. I also discussed the inherent lack of assertiveness in a Middle Eastern culture. Here, however, I would also argue the opposite: drug use is an act of assertiveness. Assertiveness, as a Western construct, is very much part of a 'freedom of choice' society. Indeed, those not asserting themselves are deemed lacking in a certain quality, as passive. Testimony to this can, for instance, be found in feminist writings: women need to assert themselves as men do. Later work questions this, and does not posit the category 'women' as needing to attain the same attributes as the category 'men'. However, it is still a dominant feature

of Western culture to regard assertiveness as a predominantly 'good thing', and a mainstay of a lot of psychotherapeutic writings ('becoming one's self against all odds' is desirable). Following on from the previous argument, 'being assertive' as part of Western culture is something that may be aspired to by those disenfranchised by their own cultural restrictions. Note that most of the qualitative sample had travelled extensively (either as airline stewards or in the military). It can be argued, then, that these people do not use drugs because they are not assertive enough, but rather that the very act of using drugs allows them to assert themselves.

This thesis has been a remarkable journey. From my initial unproblematic views of positivist psychology, "as long as I am rigorous the truth will emerge" to the influence of anthropology and sociology in problematising objectivist epistemologies, the search for meaning has been at times as exhilarating as it was daunting. Using different frameworks has enabled me to visit and re-visit literature and data, allowing me to explore alternative syntheses. I am grateful that this journey has been one of discovery and has given me the courage to explore beyond the safety network of a predominantly quantitative frame of investigation. While alienation and assertiveness were the concepts I was most focused on initially, in the final analysis it was culture (and in particular, cross-cultural differences) that made the biggest impact.

It is my conclusion that, only if the meaning of concepts such as alienation and assertiveness has been appropriately contextually defined, does it start to make sense to compare them across different cultures. The producers of knowledge are often blinded by an overly concentrated focus on methods and generalisability, at the expense of ignoring the idiosyncrasies of different contexts. To genuinely understand the addiction phenomenon in the Middle East, culturally sensitive and specific concepts need to be devised, understood and applied, rather than unproblematically transferring knowledge from elsewhere. Once

differences are comprehensively incorporated in research, exploring commonalities might be more meaningful.

REFERENCES

- Adesso, V. J. (1985). Cognitive Factors in Alcoholic and Drug Abuse. In M. Galizio and S. Maisto {Eds.}. *Determinants of Substance Abuse: Biological, Psychological and Environmental Factors* . pp.179-208. New York: Plenum Press.
- Adrian, M. (2002). A Critical Perspective on Cross Cultural Context for Addiction and Multiculturalism: Their Meanings and Implications in the Substance Use Field. *Substance Use and Misuse*, Vol. 37, Nos. 8-10, pp. 853-900.
- Albert, R. E., and Emmons, M. L. (1970). *Your Perfect Right*. St Luis: Obispos Impact.
- Al-Delaim, A., and Abdullah, F. (1997). Management of Substance Abuse in Saudi Arabia. *Derasat-Nafseyah*, Vol. 7, No. 3, pp. 470-484.
- Alexander, B. K., Hadaway P., and R. Coombs. (1980). The Rat Park Chronicle, *British Columbia Medical Journal*, Vol. 22, No. 2. (February).
- Al-Musawi, N. M. (2003). Validation of The Arabic Version of the Group Personality Projective Test Among University Students in Bahrain. *Psychological Reports*, Vol. 92, pp.389-392.
- Anderson, C. R. (1980). *A Self- Concept Study Of White Women Addicted To Heroin*. Unpublished Doctoral Dissertation, The California School of Professional Psychology, California.

- Aposhian, M. A. (1994). Iranians and the Rorschach: A Question of Cross-Cultural Validity. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, Vol. 55, No. 8-B, p. 229.
- Ashby, F.G., Prinzmental, W., Ivry, R. B . and Maddox, W. T. (1996). A Formal Theory of Feature Binding in Object Perception. *Psychological Review*, Vol. 103, pp. 165-192.
- Astin, A.W. (1963). An Empirical Characterization of Higher Educational Institutions. *Journal of Educational Psychology*, Vol. 53, pp. 224-23.
- Ayers, T. S., Sandler, I.N., West, S.G., and Roosa, M.W. (1996). A Dispositional and Situational Assessment of Children's Coping: Testing Alternative Models of Coping. *Journal of Personality*, Vol. 64, pp. 923-957.
- Aziz, S., and Shah. A. (1994). Home Environment and Peer Relations of Addicted and No addicted University Students. *Journal of Psychology*, Vol. 129, No. 3, pp. 277-284.
- Baasher, T. (1981). The Use of Drugs in The Islamic World. *British Journal of Addiction*, Vol. 76, pp. 233-243.
- Bachman, J. G., O'Malley, P.M., and Johnston, L. D. (1984) Drug Use Among Young Adults: The Impacts Of Role Status and Social Environment. *Journal of Personality and Social Psychology*, Vol. 47, No. 3, pp. 629-645.
- Bandura, A. (1977). *Social Learning Theory*. New York: Penguin.
- Bandura, A. & Walters, R. (1969). *Social Learning and Personality Development*. London: Holt Rinehart and Winston (first published 1963).

- Banadura, A. (1986). *Social Foundations of Thought and Action: A Social Cognitive Theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Banadura, M. (1977). The Anatomy of Stages of Change [Editorial]. *American Journal of Health Promotion*, Vol. 12, 8-10.
- Barrett, R. J. (1985). Behavioural Approaches to Individual Differences in Substance Abuse: Drug-Taking Behaviour. In Galizio M. and Maisto S.A. {Eds.}. *Determinants of Substance Abuse: Biological, Psychological and Environmental Factors*, pp.125-178. New York: Plenum Press.
- Beck, A. T., Wright, F. D., Newman, C.F., and Liese, B. S. (1993). *Cognitive Therapy of Substance Abuse*. New York: Guilford Press.
- Bendania, A., and Abed, A. S. (1997). Reliability and Factor Structure of an Arabic Translation of the Self-Consciousness Scale. *Psychological Report*, Vol. 81, pp. 1091-1101.
- Berridge, D., and Cleaver, H. (1987). *Foster Home Breakdown*. Oxford: Blackwell.
- Berry, J. W., Segall, M. H., and Dean, P. D. (2000). *Cross-Cultural Psychology: Research and Applications*. University Press: Cambridge., UK.
- Berzins, J. I., Ross, W.F., and Monroe, J. J. (1971). A Multivariate Study of the Personality Characteristics of Hospitalized Narcotic Addicts on the MMPI. *Journal of Clinical Psychology*, Vol. 27, No. 2, pp. 174-81.
- Botvin, G. H., Baker, E. E., Renick N. L., Filazzole, A. D., and Botvin, E. M. (1984) A Cognitive-Behavioural Approach to Substance Abuse Prevention. *Addictive Behaviours*, Vol. 9, pp. 137-147.

- Botvin, G. J. (1986). Substance Abuse Prevention Research: Recent Developments and Future Directions. *The Journal of School Health*, Vol. 59, No. 6, pp. 369-74.
- Boymal, J. (2003). Addiction and Intrapersonal Externalities in the Labour Market. *Journal of Socio-Economics*, Vol. 31, pp. 657-672.
- Bozarth, M. A. (1994). Physical Dependence Produced by Central Morphine Infections: An Anatomical Mapping Study. *Neuroscience and Biobehavioural Reviews*, Vol. 18, No. 3, pp. 373-383.
- Bozarth, M. A. (1990). Evidence for the Rewarding Effects of Ethanol Using the Conditioned Place Preference Method. *Pharmacology, Biochemistry and Behaviour*, Vol. 35, No. 2, pp. 485-7.
- Bozarth, M. A., and Wise, R. A. (1984). Anatomically Distinct Opiate Receptor Fields Mediate Reward and Physical Dependence. *Science*, Vol. 4, No. 224 (4648), pp. 516-527.
- Bracegirdle, H. (1990). Assessment of Social Skills, Theoretical Considerations and the Social Skills Model for Paediatric Occupational Therapists. *British Journal of Occupational Therapy*. Vol. 4, pp. 160-161.
- Brickman, R. (1981). The Comparative Political Analysis of Science and Technology. *Comparative Politics*, Vol. 13, No. 4, pp. 479-496.
- Brill, H. (1963). Misapprehensions about Drug Addiction - Some Origins and Repercussions. *Comprehensive Psychiatry*, Vol. 4, No. 3, pp.150-159.
- Brown, L. and Brown, M. (1986). *Dinosaurs Divorce: A Guide for Changing Families*. Boston: Little and Brown.

- Brownell, K. D. Marlatt, G. A., Lichtenstein, E., and Wilson, C. T. (1986). Understanding and Preventing Relapse. *American Psychologist*, Vol. 41, pp. 765-782.
- Brownell, K. D. and Fairburn, C. G. (2002). *Eating Disorders and Obesity: A Comprehensive Handbook*. 2nd ed . London: Guilford Press.
- Burgess, R. (1984). *In The Field*. London: Unwin Hyman.
- Burkett, S. R. (1977). Religion, Parental Influence, and Adolescent Alcohol and Marijuana Use. *Journal of Drug Issues*, Vol. 7, pp. 263-273.
- Callner, D. A., and Ross, S. M.. (1978). The Assessment and Training of Assertive Skills with Drug Addicts: A Preliminary Study. *The International Journal of the Addictions*, Vol. 13, No. 2, pp. 227-239.
- Callner, D. A., and Ross, S. M. (1976). The Reliability and Validity of Three Measures of Assertion in a Drug Addict Population. *Behaviour Therapy*, Vol. 7, pp. 659-667.
- Cappell, H., and Greeley, J. (1987). Alcohol and Tension Reduction: An Update on Research and Theory. In Blane, H .T. and Leonard, K. E. {Eds.}. *Psychological Theories of Drinking and Alcoholism*. New York: Guilford Press.
- Cadore, R. J. (1992). Genetic and Environmental Factors in the Initiation of Drug use and the Transition to Abuse. In Glantz, M. and Pickens, R. {Eds.}. *Vulnerability to Drug Abuse*. pp. 99-113. Washington, DC: American Psychological Association.
- Cardinal, P. (1986). *Islam - 20th Century: Civilization, Arabia. Islam and Politics- Arab Countries*. Paris: B Grasset.

- Cheek, F. E., Tomarchio, T., and Standen, J. (1973). Methadone Plus: A Behaviour Modification Training Program in Self-Control for Addicts on Methadone Maintenance. *The International Journal of the Addictions*, Vol. 8, No. 6, pp. 969-996.
- Cheek, F. E., and Mendelson, M. (1973). Developing Behaviour Modification Programmes with Emphasis on Self-Control. Hospital and Community Psychiatry. *The international Journal of the Addictions*, Vol. 24, No. 6, pp. 410-416.
- Coombs, R. H., Paulson, M. J., and Richardson, M. A. (1991). Peer vs. Parental Influence in Substance Use Among Hispanic and Anglo Children and Adolescents. *Journal of Youth and Adolescence*, Vol. 20, No. 1, pp. 73-88.
- Cox, W. M. (1985). Personality Correlates of Substance Abuse. In M. Galizio & S. A. Maisto {Eds.}. *Determinants of Substance Abuse: Biological, Psychological and Environmental Factors*. pp. 209-246. New York: Plenum Press.
- Dean, K. (1997). *Politics and The Ends of Identity*. Ashgate, Brookfield, USA: Aldershot,
- Davis, J. V. (1972). Reasons for Not Reporting Peak Experiences. *Journal of Humanistic Psychology*, Vol. 30, No. 1, pp. 68-84.
- Dawley, A. (1976). *Class and Community*. Cambridge: Harvard University Press.
- Deneau, G., Yanagita, T., and Seevers, M. H. (1969). Self-Administration of Psychoactive Substances by the Monkey. *Psychopharmacologia*, Vol. 16, No. 1, pp. 30-48.

Department of Health (1999). *Saving lives: Our Healthier Nation*.

HM Stationery Office: London.

Department of Health, (2002a). *The Models of Care for Substance Misuse Treatment: Promoting Quality, Efficiency and Effectiveness in Drug Misuse Treatment Services*. Full Report for Consultation. Department of Health: London.

DiClementi, C. C. (2003). *Addiction and Change*. New York. The Guilford Press.

Donovan, D. M., and Marlett, G. A. {Eds.}. (1988). *Assessment of Addictive Behaviours*. New York: Guilford Press.

Drugscope (2001). *Report To The European Monitoring Centre For Drugs and Drug Addiction*. United Kingdom Drug Situation REITOX.

Drugscope (2003). *Report To The European Monitoring Centre For Drugs and Drug Addiction*. United Kingdom Drug Situation. REITOX.

DSM-IV-TR (2000). *American Psychiatric Association*. Fourth Edition, pp. 191-295. USA.

Duaux, E., Krebs, M. O., Loo, H., and Poiries, M. F. (2000). Genetic Vulnerability to Drug Abuse. *European Psychiatry*, Vol. 15, pp. 109-114.

Edwards, G., Gross, M. M., Keller, M., and Moser, J. (1976). Alcohol-Related Problems in the Disability Perspective: A Summary of the Consensus of the WHO Group of Investigators on Criteria for Identifying and Classifying Disabilities Related to Alcohol Consumption. *Journal of Studies in Alcohol*, Vol. 37, No. 9, pp. 1360-82.

- Eggington, R., and Parker, H. (2000). Global youth networks, heroin, harm and trends, In: K. Evans and S. Alade {Eds.}. *Vulnerable Young People and Drugs*, Drugscope: UK.
- Elliott, T. R., and Gramling, S. E. (1990). Personal Assertiveness and the Effects of Social Support Among College Students. *Journal of Counselling Psychology*, Vol. 37, No. 4, pp. 427-436.
- Escandell, V. A. (2002). *Studies on Neuropsychology, Development, and Cognition, Minority and Cross-Cultural Aspects of Neuropsychological Assessment*, Ferraro-F-Richard {Eds.}. pp. 299-325. Swets and Zeitlinger Publishers: Netherlands.
- Enoch, M. A., and Goldman, D. (1999). Genetics of Alcoholism and Substance Abuse. *Addictive Disorders*, Vol. 22, No. 2, pp. 289-299.
- Erikson, E. (1968). *Identity: Youth and Crises*. New York: Norton.
- Fenigstein, A., Scheier, M.F. and Buss, A .H. (1975). Public and Private Self-Consciousness: Assessment and Theory. *Journal of Consulting and Clinical Psychology*, Vol. 43, pp. 522-527.
- Flores, P. J., and Mahon, L (1993). The Treatment of Addiction in Group Psychotherapy. *International Journal of Group Therapy*. International. Vol. 43, no (1)
- Freud, S. (1962). *The Future of an Illusion*: Chatto and Windus.
- Freud, S, (1930). Civilization, Society and Religion, SE21,59-145
- Feuerbach, L. (1984). Translated by E.Elliot. *The Essence of Christianity*. New York: Prometheus Books.

- Fromm, E. (1963). *The Sane Society*. London: Routledge Kegan Paul (*first published by Rinehart, (1955)*).
- Fromm, E. (1974). *The Anatomy of Human Destructiveness*. New York: Holt Rinehart & Winston.
- Ghodse, H. (1990). Problems of Maternal Substance Abuse in *Substance Abuse and Dependence: An Introduction for the Caring Professions*. Basingstoke: Macmillan
- Glover, E. (1932). On the Aetiology of Drug Addictions. *International Journal of Psychoanalysis*, Vol. 13, pp. 319-328.
- Goldman, M. S. (1999). Risk for Substance Abuse: Memory as Common Etiological Pathway. *Psychological Science*, Vol. 10 (3). pp. 196-198.
- Goode, E. (1970). *The Marijuana Smokers*. New York and London: Basic Books
- Gossop, M. Marsden, J., and Stewart, D. (2001). *The National Treatment Outcome Research Study After Five Years: Changing in Substance Use, Health and Criminal Behaviour During The Five Years After Intake*. National Addiction Centre, London.
- Gossop, M., Marsden, J., Stewart, D., and Tracy, S. (2002). Reduce Injection Risk and Sexual Risk Behaviours After Drug Misuse Treatment: Result from the National Treatment Outcome Research Study. *Aids Care*. Vol. 14 (1), pp. 77-93.
- Goulden, C., and Sandhi, A. (2001). *At The Margins: Drug Use by Vulnerable Young People in 1996/1999 Youth Lifestyles Survey*. Office Research, Development, Statistics Directorate: London.

- Grobe, S. J., Drew, J. A., and Fonteyn, M. E. (1991). A Descriptive Analysis of Experienced Nurses: Clinical Reasoning During a Planned Task. Research in *Nursing and Health*, Vol. 14, pp. 305-314.
- Guntrip, H. (1968). *Schizoid Phenomena Object-Relations and the Self*. London: The Hogarth Press.
- Hafeiz, H. B. (1995). Socio-Demographic Correlates and Pattern of Drug Abuse in Eastern Saudi Arabia. *Drug and Alcohol Dependence*, Vol. 38, pp. 255-259.
- Harris, E. M. (1971). A Measurement of Alienation in College Student Marijuana Users and Non-Users. *Journal of School Health*, Vol. 31, No. 3, pp.130-133.
- Hinson, R. E. (1985). Individual Differences in Tolerance and Relapse: A Pavlovian Conditioning Perspective. In M. Galizio and S. A. Maisto {Eds.}. *Determinants of Substance Abuse: Biological and Environmental Factors*, pp. 101-124. New York: Plenum Press.
- Holloway, I., and Wheeler, S. (2000). *Qualitative Research for Nurses*. London: Blackwell Science.
- Holloway, W., and Jefferson, T. (2000). *Doing Qualitative Research*. London: Sage Publications.
- Hoyle, R., Harris, M. and Judd, C. (2002). *Research Methods in Social Relations*. Thomson Learning.
- Hopkinson, K., Cox, A., Rutter, M., (1981). "Psychiatric Interviewing Techniques" II Naturalistic Study: Eliciting Factory. *British Journal of Psychiatry*, Vol. 138, pp. 283-291.

- Hopper, E. (1995). A Psychoanalytical Theory of Drug Addiction: Unconscious Fantasies of Homosexuality, Compulsions and Masturbation within the Context of Traumatogenic Processes. *International Journal of Psychoanalysis*, Vol. 76, No. 6, pp. 1121-42.
- Horney, K. (1945). *Our Inner Conflicts*. New York: Norton.
- Horney, K. (1950). *Neurosis and Human Growth: The Struggle Toward Self-realization*. London. Norton and Company.
- Horney, K. (1958). *Neurosis and Human Growth*. New York: Norton.
- Iqbal, N. (2001). Problems With Inpatient Treatment of Drug Users in Jeddah. *Annals of Saudi Medicine*. Vol. 21 (4).
- Iqbal, N. (2004). Heroin Addiction in Saudi Arabia. *Annals of Saudi Medicine*. Vol. 24, (4). pp 304-305.
- Jang, K. L., Vernon, P. A., Livesley, W. J., Stein, M. B., and Wolf, H. (2001). Intra and Extra-Familial Influences on Alcohol and Drug Misuse: A Twin Study of Gene-Environment Correlation. *Addiction*, Vol. 96, pp.1307-1318.
- Jarviluoma, H., Moisala, P., and Vikko, A. (2003). *Gender and Qualitative Methods*. London, Sage Publications.
- Jessor, R., Graves, T. D., Hanson, R. G., and Jessor, S. (1968). *Society, Personality and Deviant Behaviour*. New York: Holt, Rinehart, and Winston.
- Jessor, R., Jessor, S., and Finney, J. (1973). A Social Psychology of Marijuana Use: Longitudinal Studies of High School and College Youth. *Journal of Personality and Social Psychology*. Vol. 26, pp. 1-15.

- Johns, A. (1990). *What is Dependence? Substance Abuse and Dependence: An Introduction for the Caring Professions*. Basingstoke: Macmillan.
- Jung, J. (2001). *Psychology of Alcohol and Other Drugs*. Thousand Oaks, Calif. Sage Publication. Inc.
- Kaplan, M. (1976). *Alienation and Identification*. New York: Free Press.
- Kareem, J. and Littlewood, R. (2000). *Intercultural Therapy*. London: Blackwell Science.
- Keeler, M. H. (1969). What Are The Questions Concerning Marijuana? In Wittenborn, J. R. {Eds.}. *Drug And Youth: Proceeding Of The Rutgers Symposium On Drug Abuse*: Springfield, IL.
- Kendler, K. S., Gardner, C. O., and Prescott, C. A., (1997). Religion, Psycopathology and Substance Use and Abuse. A Multimedia, Genetic-Epidemiological Study. *American Journal of Psychology*. Vol. 145, pp. 332-329.
- Keniston, K. (1968). Why Students Become Radicals. *Journal of American College Health Association*, Vol. 17, No. 2, pp. 107-108.
- Keniston, K. (1970). Student Activism, Moral Development, and Morality. *American Journal of Orthopsychiatry*, Vol. 40, No. 4, pp. 577-592.
- Kerimi, N. (2000). Opium Use in Turkmenistan: A Historical Perspective. *Addiction*, Vol. 95, No. 9, pp. 1319-1333.

Kilpatrick, D. G., Aciermo, R., Saunders, B., Resnick, H. S., and Best, C. L. (2000). Risk Factors for Adolescent Substance Abuse and Dependence: Data from a National Sample. *Journal of Consulting and Clinical Psychology*, Vol. 68, No. 1, pp.19-30.

King, N. (1998). *Template Analysis*. London: Sage.

Kohn, P. M. and Mercer, G.W. (1973). Authoritarianism, Rebelliousness, Permissiveness about Drugs and Person Perception. *Proceedings of The 81st Annual Convention of The American Psychological Association*, Vol. 8, pp. 309-310.

Kohut, H. (1994). *Self Deficits and Addiction*. In J.D. Levin and R.H. Weiss. The Dynamics and Treatment of Alcoholism: Essential Papers. Northvale: Aronson.

Kraft, T. (1968). Successful Treatment of a Case of Drinamyl Addiction. *British Journal of Psychiatry*, Vol. 114, pp. 1363-1364.

Krystal, H. (1993). Self and Object Representation in Alcoholism and Other Drug Dependence: Implications for Treatment. In J. Blaine and D. Julius *Psychodynamics of Drug Dependence*. London: Aronson.

Laing, R. D. (1965). *The Divided Self*. Harmondsworth: Penguin.

Lazarus, R. S., and Folkman, S. (1984). *Stress, Appraisal and Coping*. New York: Springer Publishing.

Lerner, H. G. (1985). *The Dance of Anger*. New York: Harper & Row.

Levine, H. G. (1984). The Alcohol Problem in America: From Temperance to Alcoholism. *British Journal of Addiction*. Vol. 79, 109-119.

- Lichtheim, G. (1979). Alienation. *Psychoanalytic Quarterly*, Vol. 133, pp.264-268.
- Littlefield, A., Lieberman, L., and Reynolds L. T. (1982). Redefining Race: The Potential Demise of a Concept in Physical Anthropology. *Current Anthropology*, Vol. 23, pp. 641-656.
- Littlewood, R. (1998). *The Butterfly and the Serpent: Essays in Psychiatry, Race and Religion*. London: Free Association Books.
- Littlewood, R., and Lipsedge, M. (1997). *Aliens and Alienists: Ethnic Minorities and Psychiatry*. London: Routledge.
- Lloyd, M., and Bor, R. (2000). *Communication Skills for Medicine*. London, Churchill Livingstone.
- Lurie, I. (1974). Estimates of Tax Rates in the AFDC Program. *National Tax Journal*, Vol. 27, No. 1, pp. 93–107.
- Lykken, D. T. (1957). A Study of Anxiety in the Sociopathic Personality. *Journal of Abnormal and Social Psychology*, Vol. 65, pp. 6-10.
- Maisto, S. A., Cary, K. B., and Bradizza, C. M. (1999). Social Learning Theory. In K. E. Leonard and H. T. Blaine {Eds.}. *Psychological Theories of Drinking and Alcoholism*. (2nd) {Eds.}. pp. 106-163. New York: Guilford Press.
- Maisto, S. A., O'Farrell, T. J., Connors, G. J., McKay, J. R. and Pelcovits, M. (1988). Alcoholics' Attributions of Factors Affecting their Relapse to Drinking and Reasons for Terminating Relapse Episodes. *Addictive Behaviour*, Vol. 13, No. 1, pp. 79-82.

- Marlatt, G. A., and Gordon, J. R. (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviours*. New York: Penguin.
- Marlatt, G. A. (1995). *Self-Efficacy and Addictive Behaviour*. In Bandura, A., (Ed.) *Self-Efficacy in Changing Societies* New York University Press. 289-315
- Marx, K. (1844). *Economic and Philosophic Manuscripts of 1844* (Trans. by Martin Milligan 1959). London: Lawrence and Wishart.
- Maslow, A. H. (1954). *Motivation and Personality*. New York: Harper.
- Ma, X.G., and Shive, S. (2000). A Comparative Analysis of Perceived Risks and Substance Abuse Among Ethnic Groups. *Addictive Behaviours*, Vol. 25, No. 3, pp. 361-371.
- McAree, G. P., Steffenhagen, P. A., and Zheutlin, L. S. (1969). Psychological Dimensions of Anomie. *American Sociology Review*. Vol. 30(1), 14-40
- McAree, C. P., Steffenhagen, R. A., and Zheutlin, L. S. (1972). Personality Factors and Patterns of Drug Usage in College Students. *American Journal of Psychiatry*, Vol. 128, No. 7, pp. 890-893.
- McClosky, H., and Schaar, J. H. (1965). Psychological Dimensions of Anomie. *American Sociological Review*, Vol. 30, No. 1, pp. 14-40.
- McArdle, P., Wiegersma, A., Gilvarry, E., Kolte, B., McCrathy, S., Fitzgerald, M., Brinkley, A., Blom, M., Stoeckel, I., Pierolini, A., Michels, I., Johnson, R., and Quensel, S. (2002). European Adolescent Substance Use: The Roles of Family Structure, Function and Gender. *Addiction*, Vol. 97, pp. 329-336.

- Merwin, R.E. (1974). *Alienation from Society, Peers and Self: A Study of Patients and Therapist in Traditional and Free Outpatient Mental Health Clinics*. Unpublished Doctoral Dissertation, Department Of Psychology, University Of Massachusetts.
- Merwin, R.E. (1970). *Alienation from Society, Self-Estrangement and Personality Characteristics from the MMPI in Normals and Schizophrenics*. Unpublished Masters Thesis, University of Massachusetts.
- Meyer, R. E., and Mirin, S. M. (1979). *The Heroin Stimulations: Implications for a Theory of Addiction*. New York: Plenum Medical Book Company.
- Miller, N. S., Belkin, B. M., and Gold M. S. (1990). Multiple Addictions: Co-Synchronous Use of Alcohol and Drugs. *N Y State Journal of Medicine*, Vol. 90, No. 12, pp. 596-600.
- Minkin, N., Braukman, C. J., Minkin, B. L., Timbers, G. D., Timbers, B. J., Fixsen, D. L., Phillips, E. L., and Wolf, M. M. (1976). The Social Validation and Training of Conversational Skills. *Journal of Applied Behavior Analysis*. Vol. 9, pp. 127-139.
- Mizner, G. L., Barter, J .T., and Werme, P. H. (1970). Patterns of Drug Use Among College Students: A Preliminary Report. *American Journal of Psychiatry*, Vol. 27, pp. 15-24.
- Morgenstern, J., and Leeda, J. (1993). Contemporary Psychoanalytic Theories of Substance Abuse: A Disorder in Search of Paradigm. *Psychotherapy*. Vol. 30 (2).

- Murphy, S. L., and Khantzian, E. J. (1996). *Addiction as a Self-Medication Disorder: Application of Ego Psychology to the Treatment of Substance Abuse*. In A.M. Washton {Ed.} *Psychotherapy and Substance Abuse: A Practitioner's Book*. KY: Guilford
- Nathan, P. E., (1988). The Addictive Personality is The Behaviour of The Addicts. *Journal of Counselling and Clinical Psychology*. Vol. 56 (2), 183-188.
- Neal, A.G., and Seeman, M. (1964). Organization and Powerlessness - A Test of the Mediation Hypothesis. *American Sociological Review*. Vol. 29, pp.216-226
- Nemoto, T., Aoki, B., Huang, K., Morris, A., Nguyen, H., and Wong, W. (1999). Drug Use Behaviors Among Asian Drug Users in San Francisco. *Addictive Behaviors*, Vol. 24, No. 6, pp. 823-838.
- Nettler, G. (1957). A Measure of Alienation. *American Sociological Review*, Vol. 22, pp. 670-677.
- Newlin, D. B., Milles, D. R., van den Bree, M. B., Gupman, A. E., and Pickens, R. W. (2000). Environmental Transmission of DSM-IV Substance Use Disorders in Adaptive and Step Families. *Alcoholism: Clinical and Experimental Research*. Vol. 24 (12), pp. 1785-1794.
- O'Farrell, T. J., and Fals-Stewart, W. (1999). Affectivity: A Central Mechanism in The Development of Drug Dependence. In M. Glantz and R. Pickens {Eds.}. *Vulnerability to Drug Abuse*. pp. 179-210. Washington, DC: American Psychological Association.

- Orford, J. (1995). Childhood and Adulthood Influences on the Adjustment of Young Adults With and Without Parents with Drinking Problems. *Addiction Research*, Vol. 2, No.1, pp. 1-15.
- Orford, J. and Somers, M. (1996). Drinking and Gambling: A Comparison with Implications for Theories of Addiction. *Drug and Alcohol Review*, Vol. 15, No. 1, pp. 47-56.
- Osman, A., Shawoosh, M. (2003) Heroin Addiction in Saudi Arabia: Not Merely a Behavioural Problem. (Letter) *Annals of Saudi Medicine*, Vol. 23, No. 6, pp, 419-421.
- Pandina, R. J., Johnson, V., and Labouvie, E. W. (1992). Affectivity: A Central Mechanism in the Development of Drug Dependence. In M. Glantz and R. Pickens {Eds.}. *Vulnerability to Drug Abuse*. pp. 179-210. Washington, DC: American Psychological Association.
- Parks, C. W., Becker, M., Jonathan, M., Chamberlain, D., and Crandell, J. M. (1975). Eliminating Self-Defeating Behaviour and Change in Locus of Control. *The Journal of Psychology*, Vol. 91, pp. 115-120.
- Peele, S., and Degrandpre, R. J. (1998.) Cocaine and the Concept of Addiction: Environmental Factors in Drug Compulsions. *Addiction Research*, Vol. 6, No. 3, pp. 235-263.
- Petry, N. M. (2003). A Comparison of African American and Non-Hispanic Caucasian Cocaine-Abusing Outpatients. *Drug and Alcohol Dependence*, Vol. 69, pp. 43-49.
- Pickens, R. W. (2001). Family History Influence on Drug Abuse Severity and Treatment Outcome. *Drug and Alcohol Dependence*, Vol. 61, pp. 261-270.

- Pope, H. (1971). *Voices from The Drug Culture*. Boston: Beacon Press.
- Qureshi, N. A. (1992). Socio-demographic Correlates, Pattern, and Comorbidity of Drug Abuse among Psychiatric Patients. *The Arab Journal of Psychiatry*, Vol. 3, No. 2, pp. 98-106.
- Qureshi, N. A., and Al-Habeeb, T. A. (2000). Sociodemographic Parameters and Clinical Pattern of Drug Abuse in the Al-Qassim Region - Saudi Arabia. *Arab Journal of Psychiatry*, Vol. 11, No. 1, pp. 10-21.
- Qureshi, N. A. (2000). Drug Addiction. *Saudi Medical Journal*. Vol. 21, No. 1. pp. 107-108.
- Ray, O. S. (1972). *Checklist for Knowledge and Interest on Drugs and Drug Use*. Saint Louis: C. V. Mosby Co.
- Rettig, S., and Pasamanick, B. (1964). Sub-cultural Identification of Hospitalized Male Drug Addicts: A Further Examination. *Journal of Nervous and Mental Disorder*, Vol. 139, pp. 83-86.
- Riggio, R. E., Throckmorton, B., and De Paola, S. (1990). Social Skills and Self-Esteem. *Personality and Individual Differences*, Vol. 11, No. 8, pp. 799-804.
- Robins, L. N. (1980). The Natural History of Drug Abuse. In U. S. Department of Health and Human Services, Theories on Drug abuse: *Contemporary Perspectives (NIDA) Research Monograph* . No.30, pp.215-225. Washington, DC: US.
- Robins, L .N. (1975). Narcotic Use in Southeast Asia and Afterward. *Archives of General Psychiatry*, Vol. 2, pp.955-961.
- Rogers, C. (1951). *Client-Centred Therapy*. New York: Harper & Row.

- Rogers, C. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy*. New York: Harper & Row.
- Rotter, J. B. (1972). A New Scale for the Measurement of Interpersonal Trust. In Rotter, Chance, and Phares {Eds.}. *Applications of a Social Learning Theory of Personality*. Holt, Rinehart and Winston.
- Rouse, B. A., and Ewing, J. (1972). Marijuana and Other Drug Use by Graduate and Professional Students. *American Journal of Psychiatry*, Vol. 129, pp. 415-420.
- Rosenthal, H. M. (1983). On Early Alienation from the Self. *The American Journal of Psychoanalysis*, Vol. 43, No. 3, pp. 231-243.
- Sadava, S.W. (1971). A Field Theoretical Study of College Student Drug Use. *Canadian Journal of Behavioural Science*, Vol. 3, No. 4, pp. 337-346.
- Schachtel, E. (1961). On Alienation: A Concept of Identity. *American Journal of Psychoanalysis*, Vol. 21, pp. 67-89.
- Schaler, J. A. (2000). *Addiction is a Choice*. Open Court Publishing Company. USA.
- Schlenker, B. (1982). *Impression Management: The Self-Concept, Social Identity, and Interpersonal Relations*. Monterey: Brooks Cole Publishing Co.
- Schinke, S. P., and Botvin, G. J. (1991). *Substance Abuse in Children and Adolescents: Evaluation and Intervention*. Newbury Park, CA: Sage.

- Schulenberg, J., Maggs, J. L., Steinman, K. J., and Zucker. (2001). Development Matters: Taking The Long View on Substance Abuse Etiology and Intervention During Adolescence. In P. M. Monti, S. M. Colby., and T. A. O'Leary {Eds.}. *Adolescence, Alcohol, and Substance Abuse: Reaching Teens Through Brief Interventions*. pp. 19-57. New York: Guilford Press.
- Schuckit, M. (1972). A Study of Alcoholism in Half Siblings. *American Journal of Psychiatry*, Vol. 128, No. 9, pp. 1132-1136.
- Schweighofer, E. (1999). Schutz der Indigenen Umweltbewirtschaftungs-Praktiken und Kenntnisse. *Journal für Entwicklungspolitik*, Vol. 15, No. 2, pp.171-186.
- Seeman, M. (1964). Alienation and Social Learning in a Reformatory. *The American Journal of Sociology*, Vol. 69, pp. 270-284.
- Seeman, M. (1959). On The Meaning of Alienation. *American Sociological Review*, Vol. 24, pp. 783-791.
- Shiffman, S., and Wills, T. A. (1985). {Eds.}. *Coping and Substance Abuse*. New York: Academic Press.
- Solomon, R., Corbitt, J. (1977). An Opponent-Process Theory of Motivation: Temporal Dynamics of Affect. *Psychological Review*, Vol. 81, pp 119-1774.
- Smith, J. A, (2003). *Qualitative Psychology. A Practical Guide to Research Methods*. London: Sage.
- Srole, L. (1959). Social Integration and Certain Corollaries: An Exploratory Study. *American Sociological Review*, Vol. 21, pp. 709-716.

- Standish, K. (2003). The Cycle of Drug Use in Addiction: A Pathological Narcissistic Organisation. *Psycho-Analytic Psychotherapy in South Africa*. Vol. 11, No. (2) pp. 51-61.
- Steele, C. M. and Joseph, R. A. (1990). Alcohol Myopia: Its Prized and Dangerous Effects. *American Psychologist*, Vol. 45, pp. 921-933.
- Steffenhagen, R. A. (1974). *Motivation for Drug and Alcohol Abuse: A Social Perspective*. *Alcoholism and Drug Addiction Research*: Oxford University.
- Steiner, J. (1987). The Interplay between Pathological Organisations and The Paranoid-Schizoid and Depressive Positions. *International Journal of Psycho-Analysis*, Vol. 68.
- Steinglass, P. L., Bennett, L., Wolin, S., and Reiss, D. (1987). *The Alcoholic Family*. New York: Basic Book.
- Stockwell, T., Hodgson, R., Edwards, G., Taylor, C., and Rankin, H. (1979). The Development of a Questionnaire to Measure Severity of Alcohol Dependence. *British Journal of Addiction to Alcohol and Other Drugs*, Vol. 74, No.1, pp. 79-87.
- Stotts, A., DiClemente, C. C., Carbonari, J. P., and Mullen, P. (1996). Pregnancy Smoking Cessation. A Case of Mistaken Identity. *Addictive Behaviours*, Vol. 21, pp 459-471.
- Strang, J., Gossop, M., and Battersby, M. (1991). Self-Detoxification by Opiate Addicts. A Preliminary Investigation. *British Journal of Psychiatry*, Vol. 159, pp. 208-212.

- Sutherland, I., and Shepherd, J.P. (2001). Social Dimensions of Adolescent Substance Use. *Addiction*, Vol. 96, pp. 445-458.
- Sutker, P.B. (1971). Personality Differences and Sociopathy In Heroin Addicts and Non-Addict Prisoners. *Journal of Abnormal Psychology*, Vol. 78, No. 3, pp. 247-251.
- Sutker, P. B., and Allain, A. N. (1988). Issues in Personality Conceptualisation of Addictive Behaviours. *Journal of Consulting and Clinical Psychology*, Vol. (56) No. 92. pp 172-182.
- Swaim, R. C., Oetting, E. R., Thurman, P. J., Beauvais, F., and Edwards, R. W. (1993). American Indian Adolescent Drug Use and Socialization Characteristics. *Journal of Cross-Cultural Psychology*, Vol. 24, No. 1, pp. 53-70.
- Szasz, T. S. (1974). *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers*. Oxford: Oxford University Press.
- Szasz, T. S. (1987). *Insanity: The Idea and its Consequences*. New York: Wiley.
- Taviss, I. (1969). Changes in the Form of Alienation: The 1900s versus the 1950s. *American Sociological Review*, Vol. 34, pp. 46 – 57.
- Trice, H. M. (1966). *Alcoholism in America*. New York: McGraw-Hill.
- Tsuang, M. T., Lyons, M. J., and Meyer, J. M (1998). Co-Occurrence of Abuse of Different Drug in Men: The Role of Drug Specific and Shared Vulnerabilities. *Arch. Gen. Psychiatry*. Vol. 55, No.11, pp.967-972.

- Van Hasselt, V.B., Hersen, M., and Millions, J. (1979). Social Skills Training for Alcoholics and Drug Addicts: A Review. *Addictive Behavior*, Vol. 3, no. 34, pp. 221-331.
- Vijver, F.V., and Leung, K. (1997). *Methods and Data Analysis for Cross-Cultural Research*. Thousand Oaks, Calif. Sage Publications.
- Wanigaratne, S., Unnithan, S., and Strang, J. (2001). Substance Misuse and Ethnic Minorities: Issues for UK. In: D. Bhugra and R. Cochrane {Eds.}. *Psychiatry in Multicultural Britain*, Gaskell: Glasgow.
- Warner, L. A., Canino, G., and Colon, H.M. (2001). Prevalence and Correlates of Substance Use Disorders among Older Adolescents in Puerto Rico and the United States: A Cross-Cultural Comparison. *Drug and Alcohol Dependence*, Vol. 63, pp. 229-243.
- Weatherburn, D., and Lind, B. (1997). The Impact of Law Enforcement Activity on a Heroin Market. *Addiction*, Vol. 92, No. 5, pp. 557-569.
- Weatherburn, D., and Lind, B. (2001). Street-Level Drug Law Enforcement and Entry into Methadone Maintenance Treatment. *Addiction*, Vol. 96, pp. 577-587.
- Weinberg, D. (2002). On the Embodiment of Addiction. *Body & Society*, Vol. 8, No. 4, pp. 1-19.
- Weiss, R. D. (1992). The Role of Psychopathology in the Transition from Drug Use to Abuse and Dependence. In M. Glantz and R. Pickens {Eds.}. *Vulnerability to Drug Abuse*. pp.137-148. Washington, DC: American Psychological Association.

- West, J., and Al-Kaisi., H. H. (1985). An Arabic Validation of a Depression Inventory. *International Journal of Social Psychiatry*, Vol. 31, No. 4, pp. 282-289. Thousand Oaks, Calif.: Sage Publications.
- West, R. (1991). The Focus and Conduct of Clinical Trials. *British Journal of Addiction*, Vol. 86, No. 5, pp. 663-665.
- World Health Organisation. ICD-10 *Classification of Mental and Behavioural Disorder* (2004). Seventh Edition, WHO Library Controlling in Publication Data. Switzerland. pp 70-83.
- Wills, T. A., and Schiffman, S. (1985). Coping and Substance Use: A Conceptual Framework. In S. Shiffman and T. A. Wills {Eds.}. *Coping and Substance Abuse*. Orlando, FL; Acadimic Press.
- Wills, T. A. (1986). Stress and Coping in Early Adolescence: Relationships to Substance Use in Urban School Samples. *Health Psychology*, Vol. 5, pp. 503-529.
- Winick, C. (2001). A Mandatory Short-Term Methadone-to-Abstinence Program in New York City. *Mount Sinai Journal of Medicine*, Vol. 68, No. 1, pp. 41-45.
- Wise, R. A. (1988). The Neurobiology of Craving: Implications for the Understanding and Treatment of Addiction. *Journal of Abnormal Psychology*, Vol. 97, No. 2, pp. 118-132.
- Wolpe, J., and Wolpe, D. (1988). *Life Without Fear: Anxiety and its Cure*. Oakland: New Harbinger Press.
- Wolpe, J. (1969). *The Practice of Behaviour Therapy*. New York: Pergamon Press.

- Woerner, W., Bilyke, B. F., Martinussen, R., Flrtcher, J., Cucchiaro, G.,
Daglarrondo, P., Lui, M., M., and Tannock, R. (2004). The Strength
and Difficulties Questionnaire Overseas: Evaluations and
Applications of The SDQ Beyond Europe. *European Child and
Adolescent Psychiatry*. [Suppl 2] 13:11/47-11/45.
- Wurmser, L. (1993). The Addictive Process (1993). *Journal of the American
Academy of Psychoanalysis and Dynamic Psychiatry*. Vol. 21, pp. 89-
105.
- Wurmser, L. (1974). Psychoanalytic Considerations of the Aetiology of
Compulsive Drug Use. *Journal of the American Psychoanalytic
Association*, Vol. 22, pp. 820-843.
- Yamani, M. (2000). *Changed Identities*. Royal Institute of International
Affairs. London
- Zeichner, A., Pihl, R. O. and Wright, J. C. (1977). A Comparison between
Volunteer Drug Abusers and Non-Drug Abusers on Measures of Social
Skills. *Journal of Clinical Psychology*, Vol. 33, No. 2, pp. 585-590.
- Ziller, R. C. (1971). A Helical Theory Of Personal Change. *Journal for The
Theory of Social Behaviour*. Vol. 1, pp. 33-37.

APPENDICES

APPENDIX ONE : LETTER TO PARTICIPANTS - ENGLISH

Date

Dear Client

Enclosed is a booklet of Consent Form, Personal History Form and Questionnaires being distributed to a sample of clients at several Hospitals and clinics. Together they form the core of a research project in which it is hoped to learn more about the characteristics and social attitudes of drug addicts. I hope that the information gained by this project will benefit all of us in the long run. Your name will be kept confidential, as well as all responses to the questionnaires.

The success of this project depends on your response. I urge you to complete these forms and return them as soon as you can.

Your co-operation is much appreciated.

Thank you,

Bazza S. Adbulaziz

APPENDIX TWO : CONSENT FORM – QUANTITATIVE STUDY ENGLISH

I, agree to participate in the above study, the general purpose of which has been explained to me by I understand that any information gathered during the course of this study will be treated as confidential. I consent to the publication of study results as the information about myself is presented anonymously.

- 1) I have been informed that the study will involve 3 questionnaires related to drug addiction, alienation and assertiveness.
- 2) I understand that participation in the study will not affect my care and treatment.
- 3) I understand that I can withdraw my consent to participate in this study at any time , without prejudice. I understand that withdrawal from the study will not affect my care and treatment.

Participant's signature:

Researcher's signature:

APPENDIX THREE : P. H. F - ENGLISH

Date:

Code No:

Nationality: _____ **Father:** _____ **Mother:** _____

Sex: _____ **Male :** _____ **Female:** _____

Age: _____

Number of brothers: _____ **and sisters:** _____

Marital status: _____

Economic status (income) please tick one of the following:

Band a: from £ 0 to £ 15.00 _____

Band b: from £15.00 to £ 25.00 _____

Band c: from £ 25.00+ _____

Educational status: Please tick one of the following:

GCSE or similar: _____

“A” levels: _____

University degree: _____

Other (please specify): _____

Occupation:

Student: _____ **Employed:** _____ **Unemployed:** _____

If you are a student, please indicate field of study:

Where do you spend most of your life?

In a : City: _____ **Village:** _____ **Town:** _____ **country side:** _____

In which country/nation ? _____

Where do you now live permanently ? (present place of residence)?

In a : City: _____ **Village:** _____ **Town:** _____ **country side:** _____

In which country/nation ? _____

Languages spoken :

Mother tongue (specify): _____

Other languages (specify): _____

Are you : Single: _____ Separated: _____ Never married: _____

Divorced: _____ First marriage: _____ Widowed: _____

Remarriage: _____ Other (specify) : _____

Do you have children? Yes : _____ No : _____

If yes, number: _____ and age: _____ of children: _____

Have you ever run away from home? Yes : _____ No : _____

How many times? _____

How old were you?

First time : _____

Second time : _____

Subsequent(3) : _____

Have you ever attempted suicide? Yes : _____ No : _____

If yes, please explain way: _____

Have you been an inpatient in a mental hospital? Yes : ____ No : ____

For how long: _____

What was the problem? Please explain: _____

Have you ever been an outpatient in a mental hospital:

Yes: _____ No : _____

For how long: _____

What was the problem? Please explain: _____

Have you ever been hospitalised for a physical ailment?

Yes: _____ No : _____

For how long: _____

What was the problem ? please explain: _____

Have you ever been arrested or charged?
(not including traffic offences): Yes: _____ No : _____

How many times? _____

How old were you the first time? _____

On what charge(s): _____

Please specify: _____

First arrest: _____

Second arrest: _____

Subsequent arrest(s): _____

Have you ever been in jail? Yes: _____ No : _____

If you for how long:

First arrest: _____

Second arrest: _____

Subsequent arrest(s): _____

Which of these drugs do you presently use or have used in the past?

	No	Presently	Past	Past Present	&
Alcohol	_____	_____	_____	_____	
Tobacco	_____	_____	_____	_____	
Tranquillizer	_____	_____	_____	_____	
Speed or "pep"	_____	_____	_____	_____	
pills					
Sleeping pills	_____	_____	_____	_____	
L S D	_____	_____	_____	_____	
Pot or grass	_____	_____	_____	_____	
Cocaine	_____	_____	_____	_____	
Heroin	_____	_____	_____	_____	
Ecstasy	_____	_____	_____	_____	
Methadone	_____	_____	_____	_____	
Other drugs	_____	_____	_____	_____	

Does any of your family take drugs or use Alcohol heavily?

Yes: _____ **No :** _____

If yes, please (specific):

	Daily heavy	Daily light	Weekly heavy	Weekly light	None	Other	Kind of drug
Father :	_____	_____	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____	_____	_____
Siblings:							

Have you been sexually abused as a child? Yes: _____ **No :** _____

If yes by whom?

Father: _____	Mother: _____	Grandfather/mother: _____
Stepfather: _____	Stepmother: _____	Cousin: _____
Uncle: _____	Auntie: _____	Quasi-family: _____
Brother: _____	Sister: _____	Relative: _____
Stepbrother: _____	Stepsister: _____	Stranger: _____

How old were you?

Where you beaten as a child? Yes: _____ **No :** _____

If yes, by whom?

Father: _____ **Mother:** _____ **Others:** _____

How did your parents treat you as a child?

	Father	Mother
Very strictly:	_____	_____
Moderately strictly:	_____	_____
Not strictly:	_____	_____
Smothering"	_____	_____
Loving:	_____	_____
Couldn't care less:	_____	_____

Do you believe in God? Yes: _____ **No :** _____

How often do you attend?

How do you perceive:

	Very religious	Moderately religious	Not religious
Yourself:	_____	_____	_____
Your father:	_____	_____	_____

Your mother: _____

Is there ever a time now that you feel like having a fix?

Yes: ____ **No :** ____

How happy are you?

Very happy: _____ Moderately happy:_____ Unhappy_____

Additional Comments:

APPENDIX FOUR : A. S. Q - ENGLISH

Below are a number of statements about which people have different feelings. Read each statement carefully and indicate the extent of your agreement or disagreement by writing the number that shows you how you feel.

- 1) Strongly Agree.**
- 2) Agree.**
- 3) Slightly Agree.**
- 4) Slightly Disagree.**
- 5) Disagree.**
- 6) Strongly Disagree.**

Example:

Sometimes I'm bothered because I don't know how I come to be the kind of person I am.

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____

Choosing number (1) means that this statement describes your feeling in that situation. So you STRONGLY AGREE.

Notes:

- 1) No spaces are to be left blank.**
- 2) There are no right or wrong answers.**

- 1) Sometimes I am bothered because I don't know how I come to be the person I am
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 2) With everything in such a state of disorder, it's hard for a person to know where he stands from one day to the next.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 3) I have nothing in common with most people of my age.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 4) I feel I am too much what others want me to be.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 5) I often feel awkward and out of place.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 6) My dreams seldom make much sense to me.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 7) There is little use in writing to public officials because often they aren't really interested in the problems of the average man.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 8) My way of doing things is not understood by others of my age.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 9) Very often I feel like a stranger to myself.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 10) People were better off in the old days when everyone knew just how to act.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 11) I remember most of what happened in my early childhood.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 12) Nowadays a person has to live pretty much for today and let tomorrow take care of itself.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 13) It is safer to trust no one, not even so-called friends.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____

- 14) In spite of what some people say, things are getting worse for the average man.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 15) I feel I don't know myself pretty well.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 16) Every thing changes so quickly these days that I have trouble deciding which are the right rules to follow.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 17) I often do things without knowing why.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 18) It's hardly fair to bring children into the world with the way things look for the future.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 19) I often have a feeling of emptiness.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 20) Most of my friends waste time talking about things that don't mean anything.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 21) I often feel that many things our parents stood for are just going to ruin before our very eyes.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 22) Often it's hard for me to make my mind up because I don't know how I really feel about something.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 23) These days a person really doesn't know whom he can count on.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 24) Often when I have an experience I feel that it really isn't happening to me.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 25) In the group that I spend most of my time, most of the people don't understand me.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 26) It seems to me that other people find it easier to decide what is right than I do.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____

27) My daydreams seem irrelevant to me.

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____

APPENDIX FIVE : A. Q. - ENGLISH

**Below are some statements, which measure your assertiveness skills.
Please check in the appropriate number as follows:**

- 1) Very much like me.**
- 2) Rather like me.**
- 3) Slightly like me.**
- 4) Slightly unlike me.**
- 5) Rather unlike me.**
- 6) Very unlike me.**

Example:

I usually avoid complaining about bad service in a restaurant.

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____

**Choosing number 2 means that this statement describes you
most of the time.**

Note:

- 1) No spaces are to be left blank**
- 2) There are no right or wrong answers**

- 1) When somebody says something nice to me, I have difficulty accepting his or her compliment.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 2) I usually avoid complaining about bad service in a restaurant.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 3) I don't find difficulty in telling my friends not to bring drugs to my house.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 4) If I disagree with my consultant on something he said, I probably would not openly express my opinions.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 5) I never have difficulty getting up the nerve to ask girls/boys to go out for a date.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 6) In general, I believe that the only way to make new friends is to go out and find them.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 7) It is difficult for me to tell others that I like them.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 8) It is difficult for me to criticise others, even when I know that they are wrong and I am right.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 9) If I knew of a person having treatment taking drugs, I probably would not bring it up in a group meeting.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 10) I never feel shaky or nervous when I think of asking my boss for a rise.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 11) In general, I am not an out going person with the girls/boys I go out with.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 12) I am usually the leader when I am with my friends.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 13) I often don't say the nice things that I think of some people.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____

- 14) I will challenge anyone trying to push ahead of me in a queue.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 15) I find it very difficult to reject drugs, even when I really want to.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 16) I usually hesitate to make phone calls to business establishments or institutions.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 17) I usually wait for the girl/boy to make the move towards me before I make a move.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 18) I believe that following others is better than leading them yourself.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 19) I never have difficulty in paying compliments to others.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 20) If someone took the parking place that I had been waiting for, I would be irritated, but I would probably drive off without saying a word.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 21) Drugs allow me to be more aggressive and outgoing.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 22) If a policeman stopped me for speeding, I would try to talk to talk him out of it.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 23) I don't have much difficulty in starting conversations with girls/boys that I have just met.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 24) Most people seem be more aggressive and assertive than I am.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 25) I never avoid asking questions for fear of sounding stupid.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 26) If one of my friends were very depressed, I would try to cheer him/her up.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____

- 27) During any argument, I keep my real feelings to myself.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 28) If a person that I had just met at a party offered me some free drugs I would turn him/her down without any trouble.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 29) If I were applying for a job I had a lot of experience for, and the employer told me that my experience was not enough, I would try to convince him/her that it was.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 30) Showing affection to girls/boys has never been a problem for me.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 31) I tend to show my feelings rather than keeping them to myself.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 32) I don't feel embarrassed when I try to give someone a compliment.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 33) If I stopped to pick up my cleaning and they told me that some of it had been lost, I would probably just walk away without saying a word.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 34) I am open and frank about my feelings.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 35) I am afraid of asking girls/boys out because I would feel rejected if they refused.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 36) To be honest, people often take advantage of me.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 37) I don't have difficulty refusing drugs when they are offered to me.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 38) In general, I feel nervous whenever I have to talk to people in authority positions.
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____

- 39) I would not describe myself as a shy person. 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
- 40) In general, I don't hesitate to openly express my opinions when in a group of people. 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____

APPENDIX SIX : LETTER TO PARTICIPANTS – ARABIC

بسم الله الرحمن الرحيم

عزيزي المشارك

يتضمن هذا الكتيب على مسودة للتاريخ الشخصي، مقياس الاغتراب النفسي ومقياس التوكيدية. والذي يساهم في أكمال هذه الدراسة التي تسعى إلى تفسير الأسباب النفسية والاجتماعية التي تدفع الفرد إلى الإدمان على المخدرات. مشاركتكم ستكون العامل الأهم في محاولة إيجاد الحلول لهذه المشكلة.

جميع المعلومات ستحفظ في سرية تامة. الرجاء أكمال الإجابة على هذه الأسئلة وإعادتها في أسرع وقت ممكن.

وشكرا

بزه سعود عبدالعزيز

[illegible]

مقياس، الشخص، التاريخ، الاستمارة، مقياس، ومقياس، النفسي، الانجذاب

[illegible]

॥ श्रीगणेशाय नमः ॥
 ॥ श्रीगणेशाय नमः ॥

॥३॥

חא:

12:

[illegible]

.....

ॐ नमो भगवते वासुदेवाय ।

.....
 :
 :

.....
 זכרונות:

۱۴۹۶:

.....: ה' | ח' | ז' | ד' |

ଉତ୍ତର:

למנוח מלך יהודה ויהויהכין מלך ישראל

(٥) وروايات الاموال (خير) طرية الشرف في احتيازات وان سائق

.....

לְעֵינֵינוּ יִרְחֹגְלָן בְּחַיֵּת וְזָן

א: ט:

[illegible]

.....


:למנוח יצחק אבנא רבנא

.....

[illegible]

.....

לשבת יצחק אברהם ורחל

ॐ नमो भगवते वासुदेवाय ।

[illegible]

هل يستطيعون أن يستقيموا؟

١٥ :
١٦ :
١٧ :

[illegible]

.....
.....

[illegible]




			بحسب:
.....	
			بدلال:
.....	
			كيف تقيم ؟
متدين جداً	متدين	غير متدين	
			نفسك:
.....	
			والدك:
.....	
			والدتك:
.....	
			أخوتك:
.....	
			هل تشعر بأنك؟
.....	سعيد جداً:	سعيد:	غير سعيد:
.....			

APPENDIX NINE : A. S. Q. - ARABIC

مقياس الاغتراب عن الذات

الرقم:

فيما يلي مجموعة من العبارات التي تختلف مشاعر الناس حيالها، أقرأها جيداً. وحدد مدى موافقتك أو عدم موافقتك عليها وذلك بضع دائرة حول الرقم المناسب والذي يعبر عن مشاعرك.

علماً بأن:

- (1) أوافق تماماً.
- (2) أوافق.
- (3) أوافق نوعاً ما.
- (4) لا أوافق.
- (5) لا أوافق مطلقاً.

مثال:

كثيراً ما أشعر أنني غريب عن ذاتي.

- | | | | | |
|-------|-------|-------|-------|-------|
| (5) | (4) | (3) | (2) | (1) |
| | | | | |

(يشير إلى أن هذه العبارة تصف ما تشعر به ولذلك توافق عليها تماماً. 1 اختيارك للرقم)

ملاحظة:

(1) لا توجد إجابات صحيحة وأخرى خاطئة.

(2) الرجاء الإجابة على جميع العبارات.

- (1) أوافق تماماً.
- (2) أوافق.
- (3) أوافق نوعاً ما.
- (4) لا أوافق.
- (5) لا أوافق مطلقاً.

(1) أتضايق أحياناً لأنني لا أدري كيف أصبحت الشخص الذي أنا هو:

- | | | | | |
|-------|-------|-------|-------|-------|
| (5) | (4) | (3) | (2) | (1) |
| | | | | |

(2) على حالة الفوضى الموجودة في كل شيء يصعب على المرء معرفة موقعه من يوم لآخر:

- | | | | | |
|-------|-------|-------|-------|-------|
| (5) | (4) | (3) | (2) | (1) |
| | | | | |

(3) لا يوجد أي شيء مشترك بيني وبين من هم في عمري:

- | | | | | |
|-------|-------|-------|-------|-------|
| (5) | (4) | (3) | (2) | (1) |
| | | | | |

- (5)
 (4)
 (3)
 (2)
 (1)
 14 تسوء الأمور بالنسبة للشخص العادي، عكس ما يدعيه بعض الناس:
- (5)
 (4)
 (3)
 (2)
 (1)
 13 من الأسلم عدم الثقة بأحد حتى يثبت صدقه:
- (5)
 (4)
 (3)
 (2)
 (1)
 12 على المرء في وقتنا هذا أن يثبت لزوجته ولبناته أن يثق بهن:
- (5)
 (4)
 (3)
 (2)
 (1)
 11 الذي أجب ما حدث لي في طفولتي المكرة:
- (5)
 (4)
 (3)
 (2)
 (1)
 10 كانت أحوال الناس في الماضي أفضل عندما كان فرد يعرف كيف يتصرف:
- (5)
 (4)
 (3)
 (2)
 (1)
 9 كثيراً ما أشعر بأنني خيب عن ذاتي:
- (5)
 (4)
 (3)
 (2)
 (1)
 8 لا يفهم الآخرون من هم مثل في فهمي لطيفتي:
- (5)
 (4)
 (3)
 (2)
 (1)
 7 تكاد تكون القادة من الكتلة التي المسئولين قليلة، لأنهم نادراً ما يهتمون بمشاعر المرء العادي:
- (5)
 (4)
 (3)
 (2)
 (1)
 6 نادراً ما تكون أحلامي مفعولاً لي:
- (5)
 (4)
 (3)
 (2)
 (1)
 5 كثيراً ما أشعر أنني بشار وليس لي مكان في هذا العالم:
- (5)
 (4)
 (3)
 (2)
 (1)
 4 أشعر بأنني أكثر مما يريد الآخرون أن يكون:

26) يبدو أن الآخرين أكثر مني قدرة في اتخاذ القرار المناسب لهم:

(1)	(2)	(3)	(4)	(5)
.....

27) يبدو أن ليس هناك صلة بيني وبين أحلام يقظتي:

(1)	(2)	(3)	(4)	(5)
.....

APPENDIX TEN : A. Q. - ARABIC

مقياس التوكيدية

الرقم:

فيما يلي بعض العبارات التي تقيس مستوى المهارات التوكيدية لديك. الرجاء قراءتها جيداً ثم ضع دائرة حول الرقم المناسب والذي يعبر عن حالتك كما تراها.

علماً بأن :-

- (1) يعبر عن حالتي تماماً.
- (2) يعبر عن حالتي أغلب الأحيان.
- (3) يعبر عن حالتي أحياناً.
- (4) يعبر عن حالتي بعض الشيء.
- (5) لا يعبر عن حالتي.
- () يعبر عن حالتي تماماً

مثال:

أجد صعوبة في تقبل المديح من الآخرين:

(5)	(4)	(3)	(2)	(1)
.....

اختيارك للرقم (4) يعني أن هذه العبارة تعبر عن حالتك أغلب الأحيان.

ملاحظة:

- (1) لا توجد إجابات صحيحة وأخرى خاطئة.
- (2) الرجاء الإجابة على جميع العبارات.

- (1) يعبر عن حالتي تماماً.
- (2) يعبر عن حالتي أغلب الأحيان.
- (3) يعبر عن حالتي أحياناً.
- (4) يعبر عن حالتي بعض الشيء.
- (5) لا يعبر عن حالتي.

(1) لا أجد صعوبة في تقبل المديح من الآخرين:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(2) عادة ما أتجنب الشكوى من الخدمة السيئة في أي مطعم:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(3) لا أجد صعوبة في القول لأصدقائي بعدم إحضار مخدرات إلى منزلي:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(4) إن لم أوافق المشرف على شيء قاله فمن المحتمل ألا أعبر عن رأيي:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(5) لا أجد صعوبة مطلقاً في لم شجاعتي والاتصال بفتيات أسألهن الخروج:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(6) بوجه عام أعتقد إن الطريقة الوحيدة لعمل صداقات جديدة هي:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(7) أجد صعوبة في أخبار الآخرين بأنني استلطفهم:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(8) أجد صعوبة في انتقاد الآخرين، حتى عند اقتناعي بأنني على صواب:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(9) لو علمت أن شخصاً من الخاضعين للعلاج من تعاطي المخدرات فمن المحتمل أن لا أذكر ذلك في الاجتماع مع المشرف:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

21) تجعلني المخدرات أكثر جرأة وتوكيدية:

(1)	(2)	(3)	(4)	(5)
.....

22) لو أوقفني رجل المرور نتيجة الشرعة، فإنني سأحاول إقناعه بعدم إعطائي مخالفة:

(1)	(2)	(3)	(4)	(5)
.....

23) لا أعاني من صعوبة بالغة في فتح حديث مع فتاة قابلتها حديثاً:

(1)	(2)	(3)	(4)	(5)
.....

24) يبدو أن أغلب الناس أكثر جرأة وتوكيدية مني:

(1)	(2)	(3)	(4)	(5)
.....

25) لا أتحاشى مطلقاً أسئلة خوفاً من أن أبدو بمظهر الغباء:

(1)	(2)	(3)	(4)	(5)
.....

26) لو كان أحد أصدقائي يشعر بالاكتناب فإنني أحاول الترفيه عنه:

(1)	(2)	(3)	(4)	(5)
.....

27) أحتفظ بحقيقة مشاعري في داخلي أثناء أي نقاش:

(1)	(2)	(3)	(4)	(5)
.....

28) لو حاول شخص، كنت قد تعرفت عليه لتوي في حفل تقديم مخدرات لي دون مقابل فإنني لا أجد صعوبة في رفضها:

(1)	(2)	(3)	(4)	(5)
.....

29) لو تقدمت إلى عمل أملك به الكثير من الخبرة، وأخبرني صاحب العمل أن خبرتي غير كافية، فإنني أحاول إقناعه بعكس ذلك:

(1)	(2)	(3)	(4)	(5)
.....

30) إظهار العواطف للفتيات ليست مشكلة بالنسبة لي:

(1)	(2)	(3)	(4)	(5)
.....

31) أميل لإظهار عواطفي بدلاً من كبتها:

(1)	(2)	(3)	(4)	(5)
.....

(32) لا أشعر بالخجل أبداً عندما أقوم بمدح أحد:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(33) لو أخبرني العامل عند ذهابي لاستلام ملابسني أن شيئاً قد فقد منها فمن المحتمل أن أترك المصبغة دون التفوه بكلمة:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(34) أنا متفتح وصريح حول مشاعري:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(35) أخاف من طلب الفتيات للخروج معي خوفاً من الرفض:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(36) صراحة، غالباً ما يستغلني الناس:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(37) لا أجد صعوبة في رفض المخدرات حين تعرض علي:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(38) عموماً أشعر بالعصبية عندما أخطب أناساً يمثلون مواقع السلطة:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(39) لا يمكنني أن أصف نفسي بأنني شخص خجول:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

(40) بشكل عام، لا أتردد في التعبير عن رأيي بصراحة عندما أكون ضمن مجموعة من الناس:

- | | | | | |
|-------|-------|-------|-------|-------|
| (1) | (2) | (3) | (4) | (5) |
| | | | | |

APPENDIX ELEVEN : CONSENT FORM – QUALITATIVE STUDY – ARABIC

بسم الله الرحمن الرحيم

أنا المدعوأوافق على المشاركة في الدراسة السابقة,كما أوضح الباحث الهدف من هذه الدراسة . جميع المعلومات التي ستأخذ سوف تحفظ بسريته تامة. وقد تعهد الباحث في تغيير أي معلومة يستدل بها عن هويتي في حالة نشر هذه الدراسة.

(1) هذه الدراسة تتضمن التسجيل الصوتي لي وقد تعهد الباحث بالتخلص من الشريط عند تفريغ المعلومات والانتهاء من الدراسة.

(2) الاشتراك في هذه الدراسة لن يؤثر على برنامجي العلاجي.

(3) الانسحاب من هذه الدراسة في أي وقت أريد بدون إعطاء أسباب لذلك ومن دون أن يؤثر ذلك على البرنامج العلاجي الذي أخضع له.

توقيع المشارك.....

توقيع الباحث.....
التاريخ

TRANSLATION

I, agree to participate in the above study, the general purpose of which has been explained to me by I understand that any information gathered during the course of this study will be treated as confidential. I consent to the publication of study results as the information about myself is presented anonymously.

1) I have been informed that the study will involve tape recording and that these tapes will be kept confidential.

2) I understand that participation in the study will not affect my care and treatment.

3) I understand that I can withdraw my consent to participate in this study at any time , without prejudice. I understand that withdrawal from the study will not affect my care and treatment.

Participant's signature:

Researcher's signature:

Date:

APPENDIX TWELVE : ARABIC STATISTICS – DRUG USAGE

جدول رقم (134) مقارنة بوضع أعداد القضايا والمتهمين وكميات المخدرات الضبوطة في المملكة

TABLE OF DRUG USAGE STATISTICS IN SAUDI FROM 1989-2004 هـ 1425 حتى نهاية عام 1410 من عام																
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
No. Of Cases	3,383	3,396	3,548	4,287	5,848	7,303	7,474	7,339	7,736	9,407	10,727	12,204	16,325	18,154	24,399	28,737
No. Of Arrests	5,777	5,515	5,628	6,589	8,278	10,328	10,685	10,794	10,465	13,838	15,297	17,199	22,349	23,921	30,871	35,440
Hash	1,364	3,725	1,949	2,472	1,972	1,809	3,531	1,325	2,357	2,003	5,641	2,719	5,591	9,273	26,004	8,611
Opiates	1,161	28,983	11,864	16,868	29,957	155,768	23,376	16,144	16,721	5,697	5,865	13,472	4,561	2,335	5,424	113,138
Heroin	52,839	89,514	157,152	206,394	112,403	324,148	483,416	119,464	63,107	149,492	120,270	200,921	28,564	83,574	62,434	61,504
Cocaine	1,156	2,141	531	5,910	9,646	4,312	11,809	386	2,202	4,909	1,15646	708	1,529	12,666	4,139	3,718
Quat	11,875	9,893	11,921	18,518	68,192	80,693	97,821	142,436	209,320	217,497	220,234	251,615	341,419	325,879	351,986	335,947
Crack	0	0	0	0	0	0	0	0	62	1,848	36	77	1,052	1,886	863	261
Amphetamine	0	8,207	9,060	3,147	2,952	178,356	131,523	20,236	17,405	40,355	19,802	8,847	476,293	1,306,561	40,781	78,286
Tranquiliser - A	299,950	234,194	136,177	137,101	319,387	30,946	23,594	8,204	2,552	1,066	52,695	854	9	11,802	4,675	497
Tranquiliser - B	2,566,702	1,707,220	2,327,532	6,716,535	8,807,633	6,571,655	3,882,730	10,873,804	3,553,232	7,509,311	7,236,219	9,689,523	9,932,868	8,265,482	18,253,390	21,074,069
Others	241,349	138,147	6,833	111,711	41,517	13,546	2,499	32,701	1,466	11,682	8,919	4,442	15,312	10,445	67,183	3,860